2005 Federal Annual Report Children's Health Insurance Program

California

Arnold Schwarzenegger, Governor
STATE OF CALIFORNIA
January 2006

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **California**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): Healthy Families/ Medi-Cal for Children

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
_____ Separate Child Health Program Only
__X__ Combination of the above

Reporting Period: ***Federal Fiscal Year 2005*** *Note: Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04.*

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Submission Date:

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table. Please note that the numbers in brackets, e.g., **[500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	SCHIP Medicaid Expansion Program					**Separate Child Health Program**				
Eligibility						**From**	N/A	% of FPL conception to birth	N/A	% of FPL
	From	N/A	% of FPL for **infants**	N/A	% of FPL	**From**	200%	% of FPL for **infants**	250%	% of FPL
	From	3/1/98	% of FPL for children ages **1 through 5** **(would have had excess property)**	ONGOING	133 % of FPL	**From**	134%	% of FPL for **1 through 5**	250%	% of FPL
	From	3/1/98	% of FPL for children ages **6 through 16** **(would have had excess property)**	ONGOING	100 % of FPL	**From**	100%	% of FPL for children ages **6 through 16**	250%	% of FPL
	From	3/1/98	% of FPL for children ages **17 and 18** **(would have had excess property)**	ONGOING	100 % of FPL	**From**	100%	% of FPL for children ages **17 and 18**	250%	% of FPL
						From	200%	% of FPL for AIM-linked infants through 2	300%	% of FPL
						From	250%	% of FPL for infants through 18 for County/ SCHIP	300%	% of FPL

Is presumptive eligibility provided for children?		Yes		Yes
	X	Yes, for whom and how long? Beginning 7/1/03, children under 200% receiving services from a CHDP provider will be enrolled in no-cost Medicaid via the CHDP Gateway for two months. In addition, children (ages 0-1 under 200% of the FPL, ages 1-5 under 133% of the FPL, and ages 6-18 under 100% of the FPL) who are screened to the no-cost Medi-Cal program are granted presumptive eligibility into Medicaid until final eligibility determinations are made.	X	Yes, for whom and how long? Children under 200% of the FPL receiving services from a CHDP provider will be enrolled in SCHIP via the CHDP Gateway for two months.

Is retroactive eligibility available?		No	**X**	No
	X	Yes, for whom and how long? Yes, for children for up to 3 months.		Yes, for whom and how long? **[1000]**

Does your State Plan contain authority to implement a waiting list?	Not applicable			No
			X	Not for children but it does for child-linked adults who are eligible. However, the use of the waiting list will be under a parental waiver (which has not been implemented),
Does your program have a mail-in application?		No		No
	X	Yes	**X**	Yes

Can an applicant apply for your program over the phone?		No		No
	X	Yes	**X**	Yes

Does your program have an application on your website that can be printed, completed and mailed in?		No		No
	X	Yes	**X**	Yes

Can an applicant apply for your program on-line?		No		No
	Yes – please check all that apply Yes, through a Certified Application Assistant		Yes – please check all that apply Yes, through a Certified Application Assistant	
	X	Signature page must be printed and mailed in	**X**	Signature page must be printed and mailed in
	X	Family documentation must be mailed (i.e., income documentation)	**X**	Family documentation must be mailed (i.e., income documentation)
	X	Electronic signature is required	**X**	Electronic signature is required
				No Signature is required

Does your program require a face-to-face interview during initial application	**X**	No	**X**	No
		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	**X**	No		No
		Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6	**X**	Yes, if the children were covered under Employer Sponsored Insurance (ESI). However, the waiting period is waived if the ESI coverage ended in certain circumstances (i.e. change in job status, death of employee, etc.).
	Specify number of months		Specify number of months	3 months

Does your program provide period of continuous coverage <u>regardless of income changes?</u>		No		No
	X	Yes	**X**	Yes
	Specify number of months	12	Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	Death of the child, leave the State, applicant's request.		Reach age 19, non-payment of premiums, death of the child, leave the State, and applicant's request.	

Does your program require premiums or an enrollment fee?	**X**	No		No
		Yes	**X**	Yes
	Enrollment fee amount		Enrollment fee amount	$0
	Premium amount		Premium amount	$4 to $15 per month per child with a maximum of $45/month for a family.
	Yearly cap		Yearly cap	$250
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
	[500]		$4 to $15 per month per child per maximum of $45/month for a family. Applicant may pay three months in advance and receive the fourth month free. If the applicant uses Electronic Funds Transfer, he/she receives a 25% discount. The $250 yearly cap only applies to health benefit co-payments for all subscribers who reside in one household. In the event the $250 yearly co-payment cap is met, the applicant is still required to make monthly premium payments.	

Does your program impose copayments or coinsurance?	**X**	No		No
		Yes	**X**	Yes (Preventive services have no copayment. Copayments for other services limited to $5)

Does your program impose deductibles?	**X**	No	**X**	No
		Yes		Yes

Does your program require an assets test?	**X**	No	**X**	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
	[500]		**[500]**	

Does your program require income disregards?		No		No
	X	Yes	**X**	Yes
			If Yes, please describe below	
	For infants under one year of age with income between 185% and 200%.		Income greater than 200% though 300%**.**	

Is a preprinted renewal form sent prior to eligibility expiring?	**X** No	No
	Yes, we send out form to family with their information pre-completed and	Yes, we send out form to family with their information pre-completed and
	☐ We send out form to family with their information pre-completed and ask for confirmation	**X** We send out form to family with their information pre-completed and ask for confirmation
	☐ We send out form but do not require a response unless income or other circumstances have changed	☐ We send out form but do not require a response unless income or other circumstances have changed

Comments on Responses in Table:

Eligibility:
1) Infants born to mothers enrolled in (on or after 7/1/04) the California State AIM program are automatically enrolled in SCHIP through age 2 up to 300% FPL. Prior to the child's third birthday, another annual determination will be made. The child will remain in SCHIP if the income is at or less than 250% FPL. 2) County/SCHIP funded Child Expansion up to 300% FPL in four counties. These categories were not listed in the SARTS template.

2. Is there an assets test in your Medicaid Program? ☐ Yes **X** No

3. Is it different from the assets test in your separate child health program? ☐ Yes **X** No

4. Are there income disregards for your Medicaid program? **X** Yes ☐ No

5. Are they different from the income disregards in your separate child health program? **X** Yes ☐ No

6. Is a joint application used for your Medicaid and separate child health program? **X** Yes ☐ No

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)		X		X
b) Application		X		X
c) Benefit structure		X		X
d) Cost sharing (including amounts, populations, & collection process)		X	X	
e) Crowd out policies		X		X
f) Delivery system		X		X
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)		X		X
h) Eligibility levels / target population		X		X
i) Assets test in Medicaid and/or SCHIP		X		X
j) Income disregards in Medicaid and/or SCHIP		X		X
k) Eligibility redetermination process		X		X
l) Enrollment process for health plan selection		X		X
m) Family coverage		X		X
n) Outreach (e.g., decrease funds, target outreach)		X	X	
o) Premium assistance		X		X

p) Prenatal Eligibility expansion		X		X
q) Waiver populations (funded under title XXI)		X		X
Parents		X		X
Pregnant women		X		X
Childless adults		X		X

r) Other – please specify

a. **[50]**				
b. **[50]**				
c. **[50]**				

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing (including amounts, populations, & collection process)	Effective July 1, 2005, the State increased monthly premiums up to $15 per child, with a maximum of $45 a month for families. Those families who are subject to this higher premium amount are those whose income is over 200% of the FPL.
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	

h) Eligibility levels / target population	.
i) Assets test in Medicaid and/or SCHIP	
j) Income disregards in Medicaid and/or SCHIP	
k) Eligibility redetermination process	
l) Enrollment process for health plan selection	
m) Family coverage	
n) Outreach	Effective July 1, 2005, the EE/CAA reimbursement process was restored. For each successful application where a child(ren) is enrolled (in SCHIP and for each application forwarded to Medi-Cal), the EE receives $50. For each successful annual eligibility review form where a child(ren) continues to be eligible (for SCHIP), the EE receives $25.
o) Premium assistance	
p) Prenatal Eligibility Expansion	
q) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
r) Other – please specify	
a. **[50]**	
b. **[50]**	
c. **[50]**	

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

Please note that the numbers in brackets, e.g., [500] are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures
- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

Adult Measures
- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:
- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.

- Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in the first 15 months of life Not Reported Because: □ Population not covered **X** Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: Other Explain: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Health plans participating in the Healthy Families Program for the 2005-2008 contract period, which began on July 1, 2005, will be required to report this measurement.	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure:**[700]**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in children the 3rd, 4th, 5th, and 6th years of life Not Reported Because: □ Population not covered [] Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	**X** HEDIS Specify version of HEDIS used: HEDIS 2005 □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:**[7500]**	Data Source(s): Participating Healthy Families Program (HFP) health plans. Definition of Population Included in Measure: Plans provide a random sample of summary data as well as member level data that is certified by an independent auditor. The random sample is of HFP members who were three, four, five or six years old during the measurement year who were continuously enrolled in the plan during the measurement year and who received one or more well-child visit(s) with a primary care provider during the measurement year. MRMIB calculates percentages and compares the results with those submitted by the health plans. This information becomes part of the HFP Handbook, provided to members at the time of open enrollment each year. Members can then compare scores between health plans Baseline / Year: July 1, 2004 – June 30, 2005 (Specify numerator and denominator for rates) The numerator and denominator are based upon a sample of children as required by the NCQA for this HEDIS measure. The numerator and denominator are not reflective of the entire HFP population. Numerator= 13243 Denominator= 20162 Performance Progress/Year: July 1, 2004 – June 30, 2005 (Specify numerator and denominator for rates) Numerator= 20162 Denominator= 13243
		Explanation of Progress: Based upon the random sample submitted by the plans, it can be impute that 66% of all applicable HFP enrollees had a well-child visit in the measurement year.

Measure	Measurement Specification	Performance Measures and Progress
		Other Comments on Measure:**[700]** Because this is a new measure that the plans are reporting, MRMIB will work with health plans to determine if appropriate and accurate data was submitted by the plans. In addition, MRMIB will work with plans to ensure that the percentage of children increases.
Use of appropriate medications for children with asthma Not Reported Because: □ Population not covered **X** Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: **X** Other Explain: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Health plans participating in the Healthy Families Program for the 2005-2008 contract period, which began on July 1, 2005, will be required to report this measurement.	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure:**[700]**
Children's access to primary care practitioners Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	**X** HEDIS Specify version of HEDIS used: HEDIS 2005 □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: Other Explain:**[7500]**	Data Source(s): Participating Healthy Families Program (HFP) health plans. Definition of Population Included in Measure: Plans provide a random sample of summary data as well as member level data that is certified by an independent auditor. The random sample is of HFP members, ages 12 months through 18 years who were continuously enrolled in the plan during the measurement year and who had access to a primary care physician. MRMIB calculates percentages and compares the results with those submitted by the health plans. This information becomes part of the HFP Handbook, provided to members at the time of open enrollment each year. Members can then compare scores between health plans

Measure	Measurement Specification	Performance Measures and Progress
		Baseline / Year: July 1, 2004 – June 30, 2005 (Specify numerator and denominator for rates) The numerator and denominator are based upon a sample of children as required by the NCQA for this HEDIS measure. The numerator and denominator are not reflective of the entire HFP population. Numerator=305069 Denominator= 367336 Performance Progress / Year: July 1, 2004 – June 30, 2005 Numerator=305069 Denominator= 367336 Explanation of Progress: Based upon the random sample submitted by the plans, it can be impute that 83% of all applicable HFP enrollees had access to a primary care physician in the measurement year. Other Comments on Measure:
Adult Comprehensive diabetes care (hemoglobin A1c tests) Not Reported Because: **X** Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:**[7500]**	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure: **[700]**

Adult access to preventive/ambulatory health services Not Reported Because: **X** Population not covered □ Data not available Explain: □ Not able to report due to small	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used:	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]**

sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	□ Other Explain: **[7500]**	Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure:**[700]**
Adult Prenatal and postpartum care (prenatal visits): □ Coverage for pregnant women over age 19 through a demonstration **X** Coverage for pregnant women under age 19 through the SCHIP state plan Not Reported Because: Population not covered **X** Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]** The Managed Risk Medical Insurance Board does not require participating health plans to collect this data.	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:**[7500]**	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure:**[700]**

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. **Please wait until you have an enrollment number from SEDS before you complete this response.**

Program	FFY 2004	FFY 2005	Percent change FFY 2004-2005
SCHIP Medicaid Expansion Program	**35,976**	**41,286**	**14.76%**
Separate Child Health Program	**847,735**	**886,934**	**4.62%**

   A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

The SCHIP Medicaid Expansion Program numbers for FFY 2005 include California's One-Month Bridge Program. The number of children enrolled in the Bridge increased by 1,777 from 2,545 to 4,322, an increase of nearly 70%.Increases in the One Month Bridge are largely a result of counties implementing new eligibility determination systems or upgrading current systems. This includes much improved reporting for California's largest county, Los Angeles.

2. Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2003. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FY 2004 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998	1,258	82.5	13.1	0.9
1997-1999	1,244	82.2	12.8	0.8
2000-2002	968	66.5	9.6	0.6
2001-2003	893	64.0	8.8	0.6
Percent change 1996-1998 vs. 2001-2003	-29.0%	NA	-32.6%	NA

A. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.**[7500]**

3. If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	California Health Interview Survey (CHIS)
Reporting period (2 or more points in time)	2001 and 2003
Methodology	The baseline is calculated by using Medi-Cal and HFP enrollment data and the 2000 Current Population Survey (CPS) as analyzed by the UCLA Center for Health Policy Research. Technical notes can be found in *The State of Health Insurance in California: Recent Trends, Future Prospects* and at the UCLA Centers website: www.healthpolicy.ucla.edu. The methodology used for estimating the baseline did not change.
Population	CHIS is a general population survey that examines health insurance coverage, as well as numerous other issues. It surveys households through random selection and does so in five languages.
Sample sizes	2001 Survey: 55,000 households with over samples of Asian Pacific Islanders and American Indian/Alaska Natives. This sample included 5,000-6,000 adolescents and 14,000 children by proxy. 2003: Survey: 40,000 households with 4,000 adolescents and 9,000 children by proxy. Over samples were done of Koreans and Vietnamese.
Number and/or rate for two or more points in time	Half of all children (50.8%) were covered throughout the year in 2003 by their parent's employment-based insurance, a drop of 4.3 percentage points from 2001. Another 29.3% were covered all year by Medi-Cal; or Healthy Families, a substantial increase of 5.2 percentage points from 2001. Increasing enrollment in Medi-Cal and Healthy Families reflects efforts and resources invested in outreach and enrollment by voluntary organizations, as well as local children's health insurance expansion programs. It also reflects the programs are established and there is increased retention by Medi-Cal related to continuous eligibility.

Statistical significance of results	Results are statistically valid. More than 1.1 million children under age 19 were uninsured for all or part of the year in 2003 - a significant drop from the 1.5 million who had no insurance in 2001. This represents 2.4 percentage points less than 2001. When uninsured is viewed as a point in time, the number of uninsured, but not enrolled in HFP and Medi-Cal has decreased significantly. Of the 997,000 children uninsured for the entire year of 2001, 301,000 were eligible for the SCHIP program and 355,000 for Medi-Cal. Of the 782,000 children uninsured for the entire year in 2003, 224,000 were eligible for the SCHIP program and 207,000 for Medi-Cal.

A. Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

   California uses the California Health Interview Survey (CHIS) as its primary source of data for the number of uninsured. This data has a significantly larger sample size than CPS and also estimates whether children would have been eligible for SCHIP or Medi-Cal.

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

   The CHIS is considered to be more precise than CPS data. Please refer to the CHIS fact sheet, Attachment I.

   California plans to continue utilizing CHIS to measure changes in the number of uninsured children. Collection of new data for the 2005-07 CHIS survey began in July 2005 and will be completed in December 2005. Data from the 2005 survey should be available beginning in early 2007.

4. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program should skip this question)***

   While the State does not actively collect data estimating the impact of outreach and enrollment simplification, the State believes outreach and enrollment simplification played a major role in Medi-Cal's continuing increase in enrollment. The State funding for outreach campaigns stopped on July 1, 2003. However, the State continues to work closely with the David and Lucille Packard Foundation to sponsor the Connecting Kids to Healthcare Through Schools Project. This Project focuses on school-based outreach and enrollment for the SCHIP, Medicaid and Children's Expansion Programs (e.g. Healthy Kids Programs). In addition, outreach still exists at the local levels for a wide variety of Children's Expansion Programs. For many of these programs outreach and enrollment is privately funded through Foundations and Local First 5 Commissions. In those counties with Children's Expansion Programs, there have been positive impacts on both the Medi-Cal for Children and SCHIP Programs in California. Effective July 1, 2005, the EE/CAA reimbursement process was restored. For each successful application where a child(ren) is enrolled, the EE receives $50. For each successful annual eligibility review form where a child(ren) continues to be eligible, the EE receives $25. Since the State recently implemented this EE/CAA reimbursement process, there is only 3 months of data available (which is not enough) for the State to estimate how the EE process affected enrollment of children. Next year's Federal Annual Report will provide more detailed information on the overall and impact of the EE reimbursement process.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3. Progress towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives Related to Reducing the Number of Uninsured Children *(Mandatory for all states for each reporting year)**(This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)***		
□ New/revised **X** Continuing □ Discontinued Explain: 1. Increase Awareness	Goal #1: Increase The Percentage Of Medi-Cal Eligible Children Who Are Enrolled In The Medi-Cal Program.	Data Source(s): California Department of Health Services Definition of Population Included in Measure:**[700]** Methodology: Analyze changes in number of eligible children in Medicaid in FFY 2003 and 2004.
		Baseline / Year: (Specify numerator and denominator for rates)**[500]**
		Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]**
		Explanation of Progress: There has been an overall increase of 31,525 in the total number of children in Medi-Cal between June 2004 and June 2005. In the Regular Medi-Cal program, the number of children enrolled increased by 22,592 from 3,178470 to 3,201,062. In the Medi-Cal Expansion program, the number of children increased by 7,156 from 81,352 to 88,508. In California's One-Month Bridge Program, the number of children enrolled increased by 1,777 from 2,545 to 4,322. Increases in the One Month Bridge are largely a result of counties implementing new eligibility determination systems or upgrading current systems. This includes much improved reporting for California's largest county, Los Angeles.

Children Enrolled in Medi-Cal & One-Month Bridge

	June 2004	June 2005	Change	% Change
Total Medicaid	3,262,367	3,293,892	31,525	0.97%
Regular Medicaid	3,178,470	3,201,062	3,201,062	0.71%
Medicaid Expansion	81,352	88,508	88,508	8.80%
One Month Bridge:	2,545	4,322	4,322	69.82%

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Other Comments on Measure: The increase in the number of children in the regular Medi-Cal program is due to continuing minor growth in coverage for low-income families (Section 1931(b) of the Social Security Act) and efforts to facilitate the Medi-Cal application process for children through the Child Health and Disability Prevention Program (CHDP) Gateway, Express Lane application through the schools for children eligible for the National School Lunch Program, and accelerated enrollment for children through the Single Point of Entry (SPE). The increased enrollment in the Medi-Cal Expansion program appears to be attributable to the growth in applications for children only through the Gateway and SPE, since property information is not required for these applications. Seventy two percent of applications through the SPE requested coverage for children only. In order to improve enrollment in the One-Month Bridge Program, the Administration has proposed the implementation of Healthy Families Bridge performance standards for counties, starting in July 2005, to ensure that all children potentially eligible are referred to Healthy Families through the One Month-Bridge Program
□ New/revised **X** Continuing □ Discontinued Explain: 1. Increase Awareness	Goal #2: Reduce The Percentage Of Uninsured Children In Target Income Families That Have Family Income Above No-Cost Medi-Cal.	Data Source(s): "The State of Health Insurance in California: Findings from the 2001 and 2003 California Health Interview Survey" (Brown, et. al, UCLA 2004).
		Definition of Population Included in Measure:**[**
		Methodology: Analyze changes in number of eligible uninsured children between 2001 and 2003 who were eligible for Medi-Cal or Healthy Families Program.
		Performance Progress / Year: (Specify numerator and denominator for rates) Estimated reduction in the percentage of uninsured children in target income families that have family income above no cost Medi-Cal: P = N/D = 25%.
		Explanation of Progress: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Other Comments on Measure: According to the 2003 CHIS, only 9.1% for parents were unaware of HFP, compared to 23.3% who were unaware in 2001. California plans to continue utilizing CHIS to measure changes in the number of uninsured children. Collection of new data for the 2005-07 CHIS survey began in July 2005 and will be completed in December 2005. Data from the 2005 survey should be available beginning in early 2007.

□ New/revised □ Continuing **X** Discontinued Explain: 1. Increase Awareness	Goal #3: Reduce The Percentage Of Children Using The Emergency Room As Their Usual Source Of Primary Care.	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: **[700]** Other Comments on Measure: The Program does not currently collect encounter data. Therefore, it cannot determine if ER Utilization is excessive.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised **X** Continuing □ Discontinued Explain: 2. Provide An Application And Enrollment Process Which Is Easy To Understand And Use.	Goal #1: Ensure Medi-Cal And HFP Enrollment Contractor Provide Written And Telephone Services Spoken By Target Population.	Data Source(s): Enrollment Contractors/Enrollment Entities Definition of Population Included in Measure:**[700]** Methodology: Review and survey of current materials. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]**
		Explanation of Progress: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)

□ New/revised **X**□ Continuing □ Discontinued Explain: 3. Ensure That Financial Barriers Do Not Keep Families From Enrolling Their Children.	Goal #1: Limit Program Costs To Two Percent Of Annual Household Income.	Data Source(s): Internal Enrollment Data, program design data, survey data. Definition of Population Included in Measure:**[700]** Methodology: **[500]** Review and analysis. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: California continues to limit HFP costs to two percent of annual household income. With the limit of $250 for annual health benefit co-payments, based on the payment formula; it is mathematically impossible for subscribers to exceed the 5% income cap for families with incomes above 150%. Nor does HFP exceed the dollar amounts specified for families with incomes below 150%. The following table illustrates that the maximum cost sharing for a family at 150% of FPL falls well within the 5% annual cap. Other Comments on Measure: **[700]**

Children	Annual Income of a Single Parent	Maximum Annual Premium Contribution	Maximum Yearly Family Contribution (Premiums+$250 in Copays)	5% Contribution of a Family at 150% FPL
1	$19,248	$108	$358	$962
2	$24,144	$216	$466	$1,207
3+	$29,028	$324	$574	$1,451

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
X New/revised □ Continuing □ Discontinued Explain: 4. Ensure the Participation of Community Based Organizations In Outreach/Education Activities.	Goal #1: Ensure That A Variety Of Entities Experienced In Working With Target Populations Are Eligible For An Application Assistance Fee.Goal #2 Ensure that a variety of entities experienced in working with target populations have input to the development of culturally and linguistically appropriate outreach and enrollment materials.	Data Source(s): MRMIB/DHS financial records Outreach and Education Contracts/Enrolled Entity Survey Definition of Population Included in Measure:**[700]** Methodology: This report is not available, since the EE/CAA reimbursement process was recently restored on July 1, 2005. Next year's Federal Annual Report will provide more information and data on the EE/CAA reimbursement process. Review contract listing. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]**
Objectives Related to Medicaid Enrollment		
□ New/revised □ Continuing □ Discontinued Explain:**[500]**	Goal #1:	Data Source(s):**[500]**
		Definition of Population Included in Measure:**[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
□ New/revised **X** Continuing □ Discontinued Explain: 5. Provide A Choice Of Health Plans.	Goal #1: Provide each family with two or more health plan choices for their children. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: **X** Other Explain: **[7500]**	Data Source(s): Enrollment data from the HFP Administrative Vendor MAXIMUS. Definition of Population Included in Measure:**[700]** Methodology: Data extract and reports from vendor database of percent of enrollment by county and number of health plans per county. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: HFP offers a broad range of health plans for program subscribers. A total of 26 health plans participated in the program during the reporting period. Over 99.70% of subscribers have a choice of at least two health plans from which to select. The 0. 30% of subscribers who have a choice of only one health plan mostly reside in rural areas of the state where access to health care services are limited. These subscribers are enrolled in exclusive provider organization plans (EPO) that provide a broad network of providers. In 39 of 58 counties, subscribers have a choice of up to 3 or more health plans. In 2 of these 39 counties, members can choose from up to 8 health plans. Other Comments on Measure: **[700]**

		Other Comments on Measure: **[700]**

□ New/revised **X** Continuing, but restated □ Discontinued Explain: 6. Encourage The Inclusion Of Traditional And Safety Net Providers.	Goal #2: Ensure broad access in each county to Traditional and Safety Net providers for all Healthy Families Program members. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: X Other Explain: **[7500]**	Data Source(s): Participating Healthy Families Program (HFP) health plans. Definition of Population Included in Measure: Traditional and Safety Net providers (clinics, CHDP providers and hospitals) in each county, as defined in Section 12693.21 of the Insurance Code. Methodology: A $3/member discount is offered as an incentive to health plans with the highest T&SN participation in their county. Determination of plans with the highest T&SN participation: MRMIB suspplies a list of T&SN providers to the health plans and the plans report which providers are in their network., Baseline / Year: (Specify numerator and denominator for rates) T&SN participation is re-evaluated each year, based on the previous year (July 1, 2004-June 30, 2005 for the 2006/2007 determination). Health plans with the highest score for T&SN participation in each county are announced at the annual March Board Meeting. Performance Progress / Year: (Specify numerator and denominator for rates) The percentage of members who can choose a CPP is 100%. Numerator=Members established with T&SN provider. Denominator=Total HFP membership. Explanation of Progress: HFP participating health plans continue to include T&SN providers in their network and to participate in the competition to be allowed to offer the HFP product at a discount. Other Comments on Measure: **[700]**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised **X** Continuing □ Discontinued Explain: 7. Ensure That All Children With Significant Health Needs Receive Access To Appropriate Services.	Goal #1: Maintain or increase the percentage of children receiving services. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: **X** Other Explain: **[7500]**	Data Source(s): HFP enrollment, CCS, and County mental health data Definition of Population Included in Measure: Methodology: Review and analysis of mechanisms in place to serve children with significant health needs. Track complai from children with significant health needs. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Children enrolled in the HFP are referred to the Califo Children's Services (CCS) Program or county mental health departments, depending upon their special hea care needs. These referrals may originate with the health plans participating in the HFP, or from other sources such as schools or families. Reports submitt by participating plans indicated that **UPDATE**11,143 children were referred to the CCS program an increas 2% during the State fiscal year. Plan reports also indicated that **1638** children were referred to a count mental health program an increase of 6.5% during the State fiscal year. Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised **X** Continuing □ Discontinued Explain: 7. Ensure That All Children With Significant Health Needs Receive Access To Appropriate Services.	Goal #2: Ensure no break in coverage as they access specialized services. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: X Other Explain: **[7500]**	Data Source(s):**[500]** HFP enrollment, CCS, and County mental health data. Definition of Population Included in Measure:**[700]** Methodology: Review and analysis of mechanisms in place to serve children with significant health needs. Track complaints from children with significant health needs. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: Memorandums of Understanding (MOUs) between participating HFP plans and county CCS and mental health programs ensure the coordination of care for HFP subscribers. In addition, ongoing meetings and the use of newsletters allow the State, health, dental and vision plans and the county programs to maintain open communication on such topics as barriers to access, referral issues, subscriber complaints, and treatment/payment coverage. Other Comments on Measure: **[700]**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised **X** Continuing □ Discontinued Explain: 8. Ensure Health Services Purchases Are Accessible To Enrolled Children.	Goal #1: Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year. **X** HEDIS Specify version of HEDIS used: 2005 Measure for Access □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): Participating Healthy Families Program (HFP) health plans Definition of Population Included in Measure A random sample is of HFP members, ages 12 months through 18 years who were continuously enrolled in the pl during the measurement year and who had access to a primary care physician. Methodology: Plans provide a random sample of summary data as well as member level data that is certified by an independent auditor. MRMIB calculates percentages and compares the results with those submitted by the health plans.This information becomes part of the HFP Handbook provided to members at the time of open enrollment each year. Members can then compare scores between health plans Baseline / Year: July 1, 2004 – June 30, 2005 (Specify numerator and denominator for rates) The numerator and denominator are based upon a sample children as required by the NCQA for this HEDIS measure The numerator and denominator are not reflective of the e HFP population. Numerator=305069 Denominator= 367336 Performance Progress / Year: July 1, 2004 – June 30, 200 (Specify numerator and denominator for rates) Numerator=305069 Denominator= 367336 Explanation of Progress: Based upon the random sample submitted by the plans, it be impute that 83% of all applicable HFP enrollees had access to a primary care physician in the measurement ye Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised **X** Continuing □ Discontinued Explain: 8. Ensure Health Services Purchases Are Accessible To Enrolled Children.	Goal #2: Achieve year-to-year improvements in the percentage of members three to six years old who received one or more well-child visits with a primary care practitioner during the measurement year. **X** HEDIS Specify version of HEDIS used: 2005 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Measure □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): Participating Healthy Families Program (HFP) health plan Definition of Population Included in Measure: A random sample of three, four, five or six years of age tha were continuously enrolled and who received one or more well-child visits with a primary care practitioner as of December 31st during the measurement year. Methodology: Plans provide a random sample of summary data as well a member level data that is certified by an independent audi . MRMIB calculates percentages and compares the result with those submitted by the health plans.This information becomes part of the HFP Handbook, provided to members the time of open enrollment each year. Members can then compare scores between health plans Baseline / Year: July 1, 2004 – June 30, 2005 (Specify numerator and denominator for rates) The numerator and denominator are based upon a sample children as required by the NCQA for this HEDIS measure The numerator and denominator are not reflective of the e HFP population. Numerator= 13243 Denominator= 20162 Performance Progress / Year: July 1, 2004 – June 30, 2005 (Specify numerator and denominator for rates) Numerator=13243 Denominator= 20162 Explanation of Progress: Based upon the random sample submitted by the plans, it can be impute that 66% of all applicable HFP enrollees had a well-child visit in the measurement year. Other Comments on Measure: Because this is a new mea that the plans are reporting, MRMIB will work with health p to determine if appropriate and accurate data was submitte by the plans. In addition, MRMIB will work with plans to ensure that the percentage of children increases.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised **X** Continuing □ Discontinued Explain: 8. Ensure Health Services Purchases Are Accessible To Enrolled Children.	Goal #3: Achieve year-to-year improvements in the percentage of children who have received all recommended immunizations by age 2. **X** HEDIS Specify version of HEDIS used: 2005 Childhood Immunization Status □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s):Participating Healthy Families Program (H health plans Definition of Population Included in Measure: A random sample of HFP members who turn two years old during the measurement year with continuous enrollment twelve months prior to the child's second birthday. (Allowa gap: No more than one gap in enrollment of up to 45 days during the 12 months prior to their second birthday.) Methodology: Plans provide summary data as well as member level data indicate if the member received each of six immunizations DtaP/DT, OPV/IPV, MMR, HIB, Hepatitis B, and VZV. MR uses this information to assign the Combination 1 and Combination 2 values. The Combination 2 value indicates child received all of the vaccines listed and it is this value t is evaluated for the measure. MRMIB calculates percentag and compares the results with those submitted by the heal plans. This information becomes part of the HFP Handbook, provided to members at the time of open enrollment each year. Members can then compare scores between health plans. Baseline / Year: July 1, 2004 – June 30, 2005 (Specify numerator and denominator for rates) The numerator and denominator are based upon a sample children as required by the NCQA for this HEDIS measure The numerator and denominator are not reflective of the e HFP population. Numerator= 4269 Denominator=5874
		Performance Progress / Year: (Specify numerator and denominator for rates) July 1, 200 June 30, 2005 (Specify numerator and denominator for rates) Numerator= 4269 Denominator=5874
		Explanation of Progress: Based upon the random sample submitted by the plans, it can be impute that 73% of all applicable HFP enrollees received Combination 2 vaccinat in the measurement year.
		Other Comments on Measure:

Other Objectives		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Sources, methodology, time period, etc.)**
□ New/revised **X** Continuing □ Discontinued Explain: 9. Strengthen And Encourage Employer-Sponsored Coverage To Maximum Extent Possible.	Goal #1: Maintain the proportion of children under 200% FPL who are covered under an employer based plan. Adjust for increased costs. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: **X** Other Explain: **[7500]**	Data Source(s): Survey performed by the University of California, San Francisco (UCSF) August 2002. This is the most rece formal survey of HFP subscribers. Definition of Population Included in Measure:**[700]** Methodology: Random sample of recent enrollees. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: UCSF estimates crowd-out at 8%. Of this 8%, 75% indicated that they could not afford other insurance. numbers indicate that crowd-out has not affected the to any significant degree. Other Comments on Measure: **[700]**

1. WHAT OTHER STRATEGIES DOES YOUR STATE USE TO MEASURE AND REPORT ON ACCESS TO, QUALITY, OR OUTCOMES OF CARE RECEIVED BY YOUR SCHIP POPULATION? WHAT HAVE YOU FOUND?

MRMIB continues to obtain information on quality of care through health and dental plan reporting requirements and subscriber surveys. The sources of information used to obtain data on the quality of care delivered through health, dental and vision plans includes the following:

Fact Sheets: Fact Sheets are submitted by each health, dental and vision plan interested in participating in the HFP. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Some of the specific areas that are addressed include access to providers, access to plan services, including customer service, standing with regulatory entity or accrediting body, and process for handling member grievances. Fact Sheets are submitted by the plans annually.

Annual Quality of Care Reports: Each year, health and dental plans are required to submit quality of care reports based on HEDIS® and a 120-day health (and dental) assessment measure. The HEDIS® reports for health plans focus on the number of children who have been immunized and on the number of children receiving well child visits. Because preventive care is vital to young children and is the cornerstone of care provided through the HFP, the annual quality of care reports provide an indication of how well a particular plan is providing health or dental care to members. **In examining data for the last three years, the HFP has consistently met or exceeded the scores for commercial and Medicaid plans in child-relevant HEDIS® measures**

California Children's Services (CCS) and Mental Health Referral Reports: The CCS and Mental Health Referral Reports were implemented in FFY 2000 to monitor the access that eligible children have to CCS and county mental health services. On a quarterly basis, plans are required to report the number of children referred to these services. The numbers reported by plans are compared with the estimates of children expected to require CCS and county mental health services to determine whether there is adequate access to these services.

Cultural and Linguistics Services Report: This report allows staff to monitor how HFP subscribers' special needs related to language access, and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How plans assign subscribers to culturally and linguistically appropriate providers
- How plans provide interpreter services to subscribers
- How plans provide culturally and linguistically appropriate marketing materials
- A list of written materials plans make available in languages other than English

In prior years, participating plans were also required to provide a Group Needs Assessment Report that identifies the cultural beliefs of subscribers as well as evaluated community resources and the plan's provider network to provide health education and cultural and linguistic services.. Participating plans are currently required to update, on an annual basis, the plan's activities and services that were implemented as a result of the Group Needs Assessment.

Member Surveys: MRMIB uses two types of member surveys, to monitor quality and service. During open enrollment, all subscribers are given a plan disenrollment survey. The survey requests information on why members decided to switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. For further information, please see Attachment II, Open Enrollment 2005 Survey Report.

Prior to 2004, Consumer satisfaction surveys, for both health and dental plans, were conducted each year. In 2004, funding for these surveys was cut. The surveys were based on the Consumer Assessment of Health Plans Survey (CAHPS ® 3.0H). Responses from the surveys provided information on access to care (including specialty referrals), quality of provider communication with subscribers, and ratings of providers, health and dental plans and overall health and dental care. Significant findings for the program that were identified in the CAHPS ® 3.0H survey conducted in 2003 include:

- On a scale of 0-10 with "10" being the best care and "0" being the worst, at least 80 percent of families gave their health care, health plan, and personal doctor (or nurse) a rating of at least an 8.
- The aspect of care in which the highest percentage of families gave a high rating was in the overall rating of the health plan. Eighty-six percent of families rated their health plan an 8, 9 or 10.
- The percentage of families giving their personal doctor (or nurse) high ratings increased in 2003. In the 2003 survey, 82 percent of families gave their personal doctor (or nurse) a high rating; whereas in the 2002 survey, 80 percent of families gave their personal doctor (or nurse) a high rating.
- At least 86 percent of families responded positively when asked questions about how well their doctor communicates about getting needed care and about the courteousness and helpfulness of office staff.

For additional information, please see Attachment III, Healthy Families Program 2004 Report of Consumer Survey of Health Plans.

Significant findings for the program that were identified in the Dental CAHPS ® Survey (D-CAHPS ® 2.0) conducted in 2003 include:

- Approximately 65, 67 and 70 percent of families gave their dental plan, dentist's care, and personal dentist, a rating of a t least an 8, respectively, on a scale of 0-10 with "10" being the best care.
- 71 percent of families responded positively when asked questions rating their dental specialist.
- 82 percent of families responded positively when asked questions about how well their dentist communicates.
- 82 percent responded positively when asked questions about the courteousness and helpfulness of office staff.

For additional information, please see Attachment IV, Healthy Families Program 2004 Report of Consumer Survey of Dental Plans.

New funding for the CAHPs surveys was received in the 2005-2006 State budget. MRMIB is updating contract language with the vendor that performed the 2003 surveys and will begin working with the vendor in January 2006. It is anticipated that data collection for the survey will begin in May 2006.

Subscriber Complaints: MRMIB receives direct inquiries and complaints from HFP applicants. Approximately 90 percent of the inquiries are received via correspondence and ten percent through phone calls. All HFP inquiries and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of request. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints, and 4) monitor the plan's ability to meet the linguistic needs of subscribers.

2. What **strategies** does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

The State **has added** performance measures to new health and dental plan contracts that are scheduled for July 2005. These performance measures include Mental Health Utilization, Well Child visits in the first 15 months of life and Chlamydia Screening In Women which are all HEDIS® Measures. In addition based on recommendations from the HFP Quality Improvement Work Group, the State has established the means to collect encounter/claims data from health and dental plans participating in the program. The focus of encounter/claims data collection will include emergency room admissions for asthma, diabetes-Type II, Attention Deficit Hyperactivity Disorder (ADHD) and depression treatment provided in the pediatrician's office and psychotropic medications, and appropriate treatment for children with upper respiratory infection (based on HEDIS®). This mechanism will be implemented when funding is provided.

In addition to new measures, the state is exploring the development of performance targets for preventive services, incentives to meet those targets, and requirements for corrective actions when plans do not meet designated targets.

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

The Health Status Assessment Project was completed in 2004 to evaluate the changes in health status of children newly enrolled in the HFP. The project examined the physical and psychosocial benefits of having access to comprehensive medical, dental and vision insurance. The Project was conducted with financial support from the David and Lucile Packard Foundation. Under the project, MRMIB implemented a longitudinal survey of families of children who were newly enrolled in the HFP in 2001 to measure changes in access to care and health status among these children over two years of enrollment.

Results from this project showed:

- Dramatic, sustained improvements in health status for the children in the poorest health and significant, sustained increases for these children is paying attention in class and keeping up in school activities.
- Meaningful improvement in health status for the population at large.
- Increased access to care and reduced foregone health care for children in the poorest health and the population at large.
- A lack of significant variation by race and language in reports of no foregone care- the most significant variable associated with access.

The most significant improvements occurred after one year of enrollment in the program. These gains were sustained through the second year of enrollment. Because the survey does not quantify all factors that are attributable to changes in health status, it is not known how much of an impact changes in access to care has on the overall changes seen in health status. It is also not known what the underlying health status is of the children participating in this survey. Therefore, the conclusion that can be made regarding these results is that the HFP contributes to the improvements in health status by increasing access to health care services.

4. Please attach any **additional** studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

Attachment I: California Health Interview Survey

Attachment II: Open Enrollment 2005 Survey Report

Attachment III: Healthy Families Program 2004 Report of Consumer Survey of Health Plans

Attachment IV: Healthy Families Program 2004 Report of Consumer Survey of Dental Plans

Attachment V: 2003 Annual Retention Report

Please reference and summarize attachments that are relevant to specific questions

Please note that the numbers in brackets, e.g., **[7500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period? **.**
As a result of funding for the EE/CAA reimbursement ceasing on July 1, 2003, the number of interested EEs dropped from nearly 4,000 to 600. However, since EE/CAA reimbursement was re-established on July 1, 2005, the number of EEs interested in assisting families with the application process has increased to 1,207. In order to have training easily available to the EE/CAA community, MRMIB implemented an on-line training which provides instructions, tests and certifies successful individuals to assist families with their application. The web-based training is available 24 hours a day, seven days per week and can accommodate over 1,000 users at any single time. Since the implementation of the web-based training (which occurred in February 1, 2005), 321 CAAs accessed the training and became certified. With the assistance in the increasing numbers of certified EEs/CAAs, the State anticipates that the reimbursement process will contribute to a higher percentage of completed applications, which will ultimately result in quicker enrollment and access to health care benefits for children.

MRMIB continues to convene a quarterly statewide outreach workgroup meeting focusing on coordination of local outreach activities. Information sharing, CBO partnering and networking are also facilitated. In addition, the MRMIB continues to work with the David and Lucille Packard Foundation to sponsor the Connecting Kids to Healthcare through Schools Project. The Project focuses on school-based outreach and enrollment for the Healthy Families, and Medi-Cal, and County Children's Expansion Programs.

2. What **methods** have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

As a result of the loss of EE/CAA reimbursement on July 1, 2003 (which was not restored until July 1, 2005), the number of applications assisted by CAAs dramatically decreased to approximately 17.2% during the period of October 1, 2004 through June 30, 2004. Consequently, approximately 81% of all applications being received by the Single Point of Entry were incomplete and require significant follow-up with the applicant to obtain missing information and enroll the child in the appropriate program.

3. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

During the reporting period, fiscal challenges have prevented California from conducting State sponsored outreach. Past targeted outreach efforts have necessarily been discontinued.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of

FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted? Yes __X____ No _____

   If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

   2004: The HFP does not maintain any trigger mechanisms. The HFP precludes enrollment within three months of having had employer sponsored coverage.

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

2. Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions? Yes ___X___ No _____

   If yes, identify your substitution prevention provisions (waiting periods, etc.).

   Under the provisions of the AB 495 SPA, Section 1.1, four counties are authorized to serve otherwise eligible children with incomes between 250-300% FPL. These counties comply with three-month crowd-out provision for employer-sponsored insurance (ESI). In addition, infants born to mothers who are enrolled in the California State AIM Program are automatically enrolled in SCHIP with coverage beginning on the infants' date of birth and may continue through age 2. These infants fall between 200% through 300% of the FPL. The infants are not subjected to any waiting period, since coverage begins on their date of birth.

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

   2004: The manner in which the State monitors and measures substitution of coverage has not changed since the inception of the program in 1998. Crowd-out is monitored through the eligibility determination process and the collection of employer-sponsored insurance at the time of application data. Applicants are required to answer questions about each child's previous health coverage. MRMIB also monitors this process through the State's plan partners who report and forward information to the MRMIB when a child is enrolled in SCHIP and had (or has) employer-sponsored coverage within the last 3 months. If MRMIB receives this information, the State conducts a formal ESI investigation.

   Children who received employer-based health coverage 3 months prior to application are not eligible for the HFP, unless they qualify for specific exemptions. These exemptions include the following items listed below.

   • The person or parent providing health coverage lost or changed jobs;

   • The family moved into an area where employer-sponsored coverage is not available;

   • The employer discontinued health benefits to all employees;

   • Coverage was lost because the individual providing the coverage died, legally separated, or divorced;

   • COBRA coverage ended; or

   • The child reached the maximum coverage of benefits allowed in current insurance in which the child is enrolled.

4. At the time of application, what percent of applicants are found to have insurance?

   During the period of October 1, 2004 through September 30, 2005, over 44% of the children were determined to be ineligible at the time of initial application, as a result of having other insurance coverage. Of the 44% that had other insurance coverage, 3.5% had employer-sponsored insurance and over 41% were receiving health coverage through the no-cost Medi-Cal programs. For those children who were disenrolled during the annual eligibility review (AER) process, over 5.3% of the children were determined to be ineligible because they had other insurance coverage. Of the 5.3% who were disenrolled during the AER process, .01% obtained employer-sponsored insurance, while over 5% were disenrolled because they were enrolled in the no-cost Medi-Cal programs.

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

   2004: Researchers from the University of California, San Francisco Institute for Health Policy Studies examined the level of crowd-out occurring in the HFP. Their August 2002 study concluded that up to 8% of new applicants had employment-related insurance within the 3 months prior to enrolling in the HFP. The researchers found that the highest rate of “crowd-out” was in the lower income group (below 200%) and that the single largest reason parents gave for dropping employer-sponsored coverage was that it was unaffordable. More than a quarter of the “crowd-out” group reported paying more than $75 per month.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

   The redetermination processes are similar; however, the redetermination process for Medicaid is separate from SCHIP. For Medicaid, each county welfare department mails a redetermination form to the applicant one month prior to the child's anniversary date. The form must be returned before the end of the annual redetermination month. If the child is found to be eligible for Medi-Cal, the child will continue to be enrolled in Medi-Cal for an additional twelve months. If the child is not eligible for Medi-Cal the redetermination form is sent to SPE for HFP eligibility determination as long as there is parental consent. Failure to provide the completed annual redetermination form results in the discontinuance of benefits. However, should the beneficiary complete the annual redetermination required within 30 days of discontinuance, the discontinuance may be rescinded and benefits restored without a break in coverage. Note: This process has not change since the 2002 reporting period.

   In the SCHIP program, the applicant is mailed a custom pre-printed Annual Eligibility Review (AER) package at least 60 days prior to their children's anniversary date. The AER package also has an attached Add A Person form which is used to apply for any children who may now be in the home and wish to apply for both SCHIP and/or Medicaid. If the AER package has not been returned within 30 days, the applicant is contacted by telephone to confirm receipt of the AER package, offer assistance to complete the package or to provide a referral to a local agency that can provide direct assistance to complete the AER package. If the package is not received within 45 days, the applicant is sent a pending disenrollment letter and the reason for the disenrollment (e.g., no package returned, missing information requested not received, etc.). If the AER package is not received or is not completed by the end of the anniversary month, the children are disenrolled and the applicant is sent the appropriate disenrollment letter. All denial and disenrollment letters include a Program Review form to return to the program if the applicant disagrees with the adverse action

2. Please explain **the process that occurs when a child's eligibility status changes from** Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

   In Medi-Cal (California's Medicaid Program), if a subscriber is determined to be ineligible due to income (too high) at Annual Eligibility Review (AER), the application is forwarded to HFP (if the applicant has provided consent to forward the form to Medi-Cal). To improve the coordination between the two programs and ensure continuity of care, the State grants an additional one month of Medi-Cal continued coverage while the application is being processed for HFP eligibility.

   In the HFP (California's SCHIP), if a subscriber is determined ineligible due to income (too low) at AER and the applicant has provided consent to forward to Medi-Cal, the AER application is forwarded to the county welfare department (CWD) in the county of the applicant's residence for a Medicaid eligibility determination. In the event the applicant does not initially provide consent to forward the AER application to the CWD, the HFP contacts the applicant to encourage him/her to re-consider Medi-Cal and to submit authorization to forward the AER application to the CWD. In these cases, coordination between

the two programs and continuity of care are ensured by the State granting two additional months of HFP 'bridge coverage" while the application is being processed for Medi-Cal eligibility or where the HFP is obtaining the applicant's consent to forward the AER application to the CWD..

As part of the HFP bridge, California uses a detailed transmittal sheet which accompanies each application it forwards to the CWD. This sheet provides detailed subscriber information such as, the income determination used to screen for no-cost Medi-Cal eligibility for each individual subscriber, the household composition and family relationships, and the unique identification number assigned to each child on the State's Medi-Cal Eligibility Data System (MEDS). The unique Client Index Number (CIN) provides California the ability to track HFP and Medi-Cal applications, enrollment, and eligibility status of children in either program or those being transferred between programs. If the CWD determines that a child is not eligible for no-cost Medi-Cal and may be eligible for the HFP, the transmittal sheet is returned to the Single Point of Entry with the application and with any subsequent documentation for a HFP determination.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

2004: Medi-Cal uses both managed care and fee-for-service providers, whereas HFP utilizes only managed care providers. There is a significant overlap in the managed care networks for HFP and for Medi-Cal.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

X Conducts follow-up with clients through caseworkers/outreach workers

X Sends renewal reminder notices to all families

X *How many notices are sent to the family prior to disenrolling the child from the program?*

The HFP sends the applicant an AER packet 60 days before the information is required to be returned, a reminder post-card 30 days after the AER package is sent, conducts courtesy calls to the applicant if an AER packet is not returned in 30 days to remind the applicant to submit the AER information, a pending disenrollment letter sent 15 days prior to the child being disenrolled from the SCHIP. The pending disenrollment letter is accompanied by a Continued Enrollment form which can be used to appeal the pending disenrollment. If the CE form is received prior to the prospective disenrollment, coverage will continue for an additional month or until the appeal is adjudicated.

X *At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)*

The HFP sends the applicants their AER packets 60 days before the information is required to be returned to the State. If the AER packets have not been returned, the applicants receive AER Courtesy calls and reminder post-cards 30 days after the AER packages were sent to them.. In addition, pending disenrollment letters are mailed to the applicants 15 days prior to the children being potentially disenrolled and is accompanied with a Continue Enrollment form.

_____ Sends targeted mailings to selected populations
Please specify population(s) (e.g., lower income eligibility groups) **[500]**

_____ Holds information campaigns

X Provides a simplified reenrollment process,
Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

Custom pre-printed re-enrollment package in 10 languages.

_____ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment

Please describe:

_____ Other*, please explain*: **[500]**

2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

Same as 2004 – Currently, the HFP does not have data measuring the effectiveness of measures taken to retain eligible children.

3. Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

   ___**X** Yes

   _____No

   When was the monthly report or assessment last conducted? 2002

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

Our monthly reports on disenrollment are on the MRMIB website, (www.mrmib.ca.gov). Charts can be found on avoidable, as well, as unavoidable disenrollments. In addition, In April 2005, the MRMIB conducted an annual retention report for the period of January 1, 2003 through December 31, 2003, please refer to Attachment V.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP:

Total Number of Dis-enrollees	Obtain other public or private coverage		Remain uninsured		Age-out		Move to new geographic area		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
201,628	4033	2%	N/A	N/A	2016	1%	N/A	N/A		

Retention report conducted annually based on analysis of actual enrollment data. In summary, 30% of families disenroll after one year due to unavoidable reasons such as obtaining other coverage, aging out and requested disenrollment. 14% disenroll due to not returning the annual review and an additional 11% due to non-payments.

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

The HFP assesses and reports a wide variety of enrollment and disenrollment related information on the MRMIB website (www.mrmib.ca.gov) on a monthly basis. This information also details the number and reasons children disenroll from the HFP. These reasons include children who do not re-enroll at their AER, not eligible at AER, age out of the program (i.e., reach age 19), and those who obtain other insurance at AER. In addition, MRMIB conducts an annual Retention Report which details the reasons subscribers do not stay in the program. This report is also posted on the MRMIB website.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   California continues to use two surveys of families to assess subscriber children who are disenrolled from the Program due to non-payment of premiums. The first is post card survey which is mailed to every applicant after their child(ren)'s disenrollment from the Program for non-payment of premiums. This survey includes question about premiums and the cost of the Program. The applicant is asked to indicate which of the following reason best describes the reason they

did not pay their premium: 1) cannot afford payment, 2) lost invoices, 3) never received invoice, and 4) forgot to pay premium.

The second survey is in conjunction with the non-payment courtesy call initiated by an HFP operator 10 days prior to disenrollment from the Program for non-payment of premium. During this call, the applicant is reminded that a premium payment is necessary in order to keep their child enrolled in the Program. If the applicant indicates they will not be making the payment, the HFP operator attempts to establish the reason why the applicant is not able to make the payment. These reasons include, "Cannot afford the premiums".
From responses to these surveys, the State has found that it is often the case that applicants that want to disenroll their child frequently quit paying their premium rather than providing the HFP with formal notice of disenrollment. Both of these surveys are on a voluntary basis. However, based on both surveys it appears that only a very small percentage of those applicants who do respond are disenrolling from the Program because they cannot afford the cost of the monthly premium.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

   The State has not conducted an assessment of the effect of cost sharing on utilization of health services. However, many services provided in the HFP do not require copayments. The program was designed with this feature to eliminate a potential barrier to services. Preventative health and dental services and all inpatient services are provided without copayment. Copayments are also not required for services provide to children through the California Children's Services Program and the county mental health departments for children who are Seriously Emotionally Disturbed (SED).

3. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found?

   Effective July 1, 2005, the State increased monthly premiums up to $15 per child, with a maximum of $45 a month for families. Those families who are subjected to the higher premium amount are those whose income is over 200% of the FPL. Approximately 25% of existing families who had children enrolled in the SCHIP were impacted by this higher premium. Families who were affected by the premium increase were sent notification about this change and given the opportunity to lower their premiums. When comparing the percentage of children being disenrolled because of non-payment of premiums during the period in which the premium increase occurred (July 1, 2005 through September 2005) with earlier periods (October 2004 through June 2005), there was a noted increase of disenrollments at the time of implementation, however, current data shows a slight increase in disenrollments of those impacted. Since the State recently implemented this higher premium, the State has not assessed the impact of this change on the application, enrollment, disenrollment and utilization of health services.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

   Yes _____ please answer questions below.

   No **_X_**skip to Section IV.

Children

____ Yes, Check all that apply and complete each question for each authority.
____ Premium Assistance under the State Plan
____ Family Coverage Waiver under the State Plan
____ SCHIP Section 1115 Demonstration
____ Medicaid Section 1115 Demonstration
____ Health Insurance Flexibility & Accountability Demonstration
____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

____ Yes, Check all that apply and complete each question for each authority.
____ Premium Assistance under the State Plan (Incidentally)
____ Family Coverage Waiver under the State Plan
____ SCHIP Section 1115 Demonstration
____ Medicaid Section 1115 Demonstration
____ Health Insurance Flexibility & Accountability Demonstration
____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

____ Parents and Caretaker Relatives

____ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.) **[7500]**

4. What benefit package does the program use? **[7500]**

5. Does the program provide wrap-around coverage for benefits or cost sharing? **[7500]**

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period
_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any that occurred or was prevented as a result of your premium assistance program. How was this measured? **[7500]**

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced? **[7500]**

9. During the reporting period, what accomplishments have been achieved in your premium assistance program? **[7500]**

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured? **[7500]**

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured? **[7500]**

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.) [7500]**

SECTION IV: PROGRAM FINANCING FOR STATE PLAN WILL BE UPDATED BY GINNY/DENNIS

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period = Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2004**	**2005**	**2006**
Insurance payments			
Managed Care	950,098,988	1,146,463,251	1,407,055,371
per member/per month rate @ # of eligibles			
Fee for Service	85,491,339	221,858,750	261,641,538
Total Benefit Costs	1,035,590,327	1,368,322,001	1,668,696,910
(Offsetting beneficiary cost sharing payments)	(48,863,495)	(45,214,863)	(52,033,174)
Net Benefit Costs	$986,726,832	$1,323,107,138	$1,616,663,736

Administration Costs			
Personnel			
General Administration	52,655,108	61,696,696	62,222,786
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	2,341,443	4,113,550	12,928,300
Other **[500]**			
Health Services Initiatives			
Total Administration Costs	54,996,551	65,810,246	75,151,086
10% Administrative Cap (net benefit costs ÷ 9)	109,636,315	147,011,904	179,629,304

Federal Title XXI Share	661,557,375	877,742,800	1,073,229,134
State Share	380,166,008	511,174,584	618,585,688

TOTAL COSTS OF APPROVED SCHIP PLAN	104,172,3383	1,388,917,384	1,691,814,822

2. What were the sources of non-Federal funding used for State match during the reporting period?

- **X** State appropriations
- **X** County/local funds
- _____ Employer contributions
- _____ Foundation grants
- _____ Private donations
- _____ Tobacco settlement
- _____ Other (specify) **[500]**

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

4. Please provide budget information in the following table. *Note: This reporting period (Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2004**	**2005**	**2006**	**2007**	**2008**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					

Fee for Service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3 (e.g., pregnant women)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4 (e.g., childless adults)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)* **[500]**					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)? **[500]**

Please provide a description of any assumptions that are included in your calculations. **[7500]**

Other notes relevant to the budget: **[7500]**

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

   The state's difficult fiscal condition remains a challenge. Staffing reductions and associated staff turnover due to burnout continues to make managing the program difficult. The following describes a number of fiscal impacts to the program:

   a. A rate freeze was imposed on the health, dental and visions plans participating in the HFP for the period of July 2004 through June 2005.
   b. Effective July 1, 2005, the Healthy Families Program (HFP) increased its premiums for families with income greater than 200% of the federal poverty level through 250% of the federal poverty levels. This is the first premium increase since the program opened in 1998. Premiums will increase from $9 to $15 with a maximum of $45 per family. Those families that choose the Community Provider Plan will increase from $6 to $12 with a maximum of $36 per family. With the increase, the relationship of premium/income will be restored to the same percentage of income it was when the program began.
   c. In 2004, funding for CAHPS ® was cut. Funding has now been restored for the 2005-2006 State fiscal year.
   d. Lack of funding for application assistance made any attempts to increase public awareness and program growth for the SCHIP difficult. These funds were restored July 1, 2005.
   e. Lack of funding required creativity to get resources such as grants for any additional projects that could enhance the program as well as any type of survey , study or research projects.

   There continues to be strong interest and support for coverage for children, both in the Administration and the Legislature. There were no limits placed on enrollment in the Governor's Budget. In addition, legislation was signed by the Governor to expand local coverage of children without insurance. This expansion will be accomplished through a county "buy-in" that will use the HFP administrative model to develop coverage. The buy-in will be accomplished without federal or state cost.

2. During the reporting period, what has been the greatest challenge your program has experienced?

A. **Transition of Administrative Vendor:**

In last year's Federal Annual Report, it was reported that a major challenge was the transition to a new administrative vendor which occurred on January 1, 2004. This was the first transition that transpired since the program began in 1998. While the MRMIB and Department of Health Services continues to work closely with the administrative vendor to resolve system and operational issues. This task continued during the reporting period. The system is working well now.

B. **Appeals Backlog**:

As a result of the transition to a new administrative vendor, staffing reduction, and turnover of experienced staff, the MRMIB experienced a growing volume of appeals to adjudicate.

3. During the reporting period, what accomplishments have been achieved in your program?

A. SYSTEM ENHANCEMENTS:

As a result of transitioning to a new administrative vendor, there have been many improvements to the system, which include the following items as noted below. The enhancements to the system have improved operational efficiency and customer service to the public, plan partners and Enrollment Entities:

- Enhancements to HFP Website:

  The Healthy Families Program website is now available in English and Spanish. Considering that over 50% of enrolled subscribers are from the Hispanic/Latino population, the enhancement to make the website available in Spanish was a huge accomplishment. In addition, when the consumer conducts a search for a provider on the website, the website now has the improved capability to provide mapping capabilities and accurate driving directions to any provider site selected by the consumer.

- Electronic (Paperless) Environment:

  All incoming and outgoing correspondence received are now stored into the system as an image in a paperless environment. This process is extremely efficient as state and program representatives are able to immediately retrieve and access the documents when assisting the applicants or when adjudicating appeals.

- On-line Eligibility Verification System (OEVS):

  Another enhancement includes the On-line Eligibility Verification System (OEVS) which is now available to all plans that provide services to SCHIP. The OEVS is a "real-time" verification process that allows the plans to confirm a subscriber's effective date of coverage or disenrollment date in SCHIP.

- Recorded Phone Calls:

  All incoming and outgoing phone calls are recorded. This process allows MRMIB and the administrative vendor to monitor and review the type of information that is communicated to the public.

B. EE/CAA On-line Training:

In response to the anticipated demands to certify persons interested in becoming a CAA, California implemented a Web-Based Training curriculum on February 1, 2005. This on-line curriculum provides instructions, tests and certifies successful participants to assist families with their applications. It also provides links to valuable resources (e.g., Healthy Families website) and the web-based electronic application (e.g. Health-e-App). This web-based training is available 24 hours a day, seven days per week and can accommodate over 1,000 users at any single time. This curriculum will eliminate most of the need for face-to-face training, expect for isolated areas that may not be accessible to the internet. Since the implementation of the web-based training, 321 CAAs accessed the training and became certified.

C. 9001:2000 ISO Certified:

California's SCHIP is the first program that received 9001:2000 ISO Certification. The Certification confirms that the SCHIP has verifiable documented processes for actions such as document control, inspections control, corrective actions and training. The certification process requires methods for measuring customer satisfaction, continued improvement to the quality system structure, management commitment and internal controls, specific and measurable quality objectives, as well as documentation and records that support the quality management system, be achieved and accomplished.

D. EE/CAA Reimbursement Funding Restored**:**

Effective July 1, 2005, the EE/CAA reimbursement process was restored. Working closely with the administrative vendor, MRMIB successful established and implemented the EE/CAA reimbursement process. When the EE/CAA reimbursement funding ceased on July 1, 2003, the number of Enrollment Entities (EEs) dropped from nearly 4,000 to 600. As a result of the EE/CAA reimbursement process being re-established, within 3 months, the number of EEs increased to 1,207. In addition, the number of applications being assisted by EEs increased to 33.2%. The State anticipates that, with the restoration of the EE/CAA reimbursement, this process will continue to contribute to an ongoing higher percentage of complete applications being received, which will ultimately result in quicker enrollment and access to health care benefits for children.

E. Center for Health Literacy & Communications Program:

The program's administrative vendor also has a Center for Health Literacy and Communications Program (whose primary focus is to develop and create culturally linguistic materials), as well as a separate Advisory Panel who reviews and provides recommendations on all program materials in English, Spanish, Vietnamese, Chinese and Korean. The Advisory Panel is comprised of representatives from community-based organizations who are fluent in each of the languages which the program materials are produced. The Advisory Panel conducts meetings on a quarterly basis to review and provide recommendations on program materials and outreach strategies to local communities.

F. AIM-linked Infants Enrolled in the HFP:

The SCHIP expanded comprehensive health care coverage to include infants born to mothers enrolled in (on or after 7/1/04) the California State AIM program. These infants are automatically enrolled in SCHIP through age 2 up to 300% FPL. If the child's income is below 300% of FPL, the child will remain eligible. Prior to the child's third birthday, another annual determination will be made. The child will remain in SCHIP if the income is at or less than 250% FPL.

G. New Staff Retention & Training:

While MRMIB experienced a high number of staff turnover during this reporting period, the MRMIB recruited new staff to fill those vacancies. All new staff have been adequately trained and staff retention is constant.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

Effective July 1, 2005, the application assistance reimbursement process was restored

Effective July 1, 2005, the Healthy Families Program (HFP) increased its premiums for families with income greater than 200% of the federal poverty level through 250% of the federal poverty levels.

Funding for CAHPS ® was restored. It is anticipated that a new survey will begin in May 2005.

The Administration plans to update and revise the joint MC/HFP application for the first time in 6 years. Originally, in last year's Federal Annual Report, it was identified that the revisions to the application would be completed during this reporting period. While revisions to the application have been made during this reporting period, the State decided to conduct a readability assessment process. The final revisions to the application will not be completed until the next reporting period. The revision will ensure that the application is at an appropriate reading level and is easier to understand.

The Administration will establish bridge performance standards to ensure that the county welfare departments place a child, who has lost Medi-Cal eligibility onto the "bridge," while the child obtains HFP coverage. The counties will comply with the requirements to forward applications to the HFP. This process will be implemented in order to minimize barriers and will ensure that children, who are eligible for SCHIP, continue to obtain comprehensive coverage. While this change was reported in last year's Federal Annual Report, this process was not implemented, as it is contingent on the joint MC/HFP application being finalized.

Staffing at MRMIB to address appeals backlogs and administrative vendor monitoring and fiscal accountability has been partially restored.

MRMIB is waiting for approval on a State Plan Amendment, requesting to obtain federal funds for pregnant women who are enrolled in the no-cost Medi-Cal and Access for Infants & Mothers (AIM) programs for prenatal care. The SCHIP already expanded comprehensive health care coverage to include infants born to mothers enrolled in (on or after 7/1/04) the AIM program. These infants are automatically enrolled in SCHIP through age 2 up to 300% FPL.

MRMIB will be working with counties to expand local coverage of children without insurance. This expansion will be accomplished through a county "buy-in" that will use the HFP administrative model to develop coverage. The buy-in will be accomplished without federal or state cost.

Attachments

Attachment I: California Health Interview Survey

Attachment II: Open Enrollment 2005 Survey Report.

Attachment III: Healthy Families Program 2004 Report of Consumer Survey of Health Plans

Attachment IV: Healthy Families Program 2004 Report of Consumer Survey of Dental Plans

Attachment V: 2003 Annual Retention Report

Attachment I:

California Health Interview Survey

UCLA CENTER FOR HEALTH POLICY RESEARCH

FOR IMMEDIATE RELEASE
December 14, 2004

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494,000 MORE OF CALIFORNIA'S CHILDREN HAD HEALTH INSURANCE COVERAGE IN 2003 THAN IN 2001

Medi-Cal and Healthy Families prove very effective in covering children as employment-based coverage declined between 2001 and 2003.

Los Angeles, CA – More than 1.1 million children under age 19 were uninsured for all or part of the year in 2003—a significant drop from the 1.5 million who had no insurance in 2001, according to a new report released by the UCLA Center for Health Policy Research.

"This is good news for California's children but we cannot stop here. We need to assure continuous coverage for all the state's children by strengthening and expanding Medi-Cal and Healthy Families" says E. Richard Brown, founding director of the Center and lead author of the study.

Children's Insurance Coverage Increases as Result of Public Program Expansion is the Center's first study based on data from the 2003 California Health Interview Survey (CHIS 2003). The fact sheet examines children's health insurance coverage, and children who are uninsured but eligible for coverage through public programs. It also describes how the profile has changed since 2001. CHIS 2003 provides the most recent information available on health insurance coverage of Californians, both statewide and at the county level. The study was funded by grants from The California Wellness Foundation and The California Endowment.

Children's coverage through a parent's employment-based insurance dropped 4.3 percentage points from 2001, while children's Medi-Cal or Healthy Families coverage increased 5.2 percentage points. The authors conclude that Medi-Cal and Healthy Families were effective in covering children as employment-based coverage declined for both children and adults between 2001 and 2003. If children's Medi-Cal and Healthy Families enrollment had increased only as much as adult enrollment in these programs, an additional 487,000 children would have been uninsured in 2003.

The effectiveness of these public programs in assuring that children are covered for health care expenses, combined with the availability of federal matching funds for Medi-Cal and Healthy Families expenditures, underscores their potential for offsetting at least some of the loss in job-based insurance.

-more-

The study also examines the importance of the county-based health insurance programs in filling gaps in coverage for California's children. "Local public and private resources were key to initiating innovative programs," noted Shana Alex Lavarreda, a Senior Research Associate at the Center, "but they are unsustainable without support from federal and state funds." Most have already reached their enrollment caps.

Brown noted that continuous eligibility of children in Medi-Cal played a major role in the dramatic change in the numbers of children now covered, together with the extensive effort and resources invested in outreach and enrollment by State and local agencies, voluntary organizations, and local children's health insurance expansion programs.

For more information about the California Health Interview Survey, please visit www.chis.ucla.edu.

The California Health Interview Survey (CHIS) is a collaboration of the UCLA Center for Health Policy Research, the California Department of Health Services and the Public Health Institute.

—UCLA—

Some Online Resources:

Children Now:	www.childrennow.org
PICO California:	www.picocalifornia.org
Children's Defense Fund California	http://www.cdfca.org
The Children's Partnership	www.childrenspartnership.org
The 100% Campaign	www.100percentcampaign.org

HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS BY COUNTY AND REGION, AGES 0-18, CALIFORNIA, 2003

	Uninsured All or Part Year		Job-Based Insurance All Year		Medi-Cal or Healthy Families All Year		Total Population Ages 0-18 2003
	2003	Percentage Point Change from 2001	2003	Percentage Point Change from 2001	2003	Percentage Point Change from 2001	
Northern & Sierra Counties	12.1%	—4.4	44.7%	—6.0	34.5%	+10.1	332,000
Butte	8%	—	45%	NS	40%	+	52,000
Shasta	15%	NS	45%	NS	35%	NS	44,000
Humboldt, Del Norte	12%	NS	42%	NS	36%	NS	36,000
Siskiyou, Lassen, Trinity, Modoc	17%	NS	39%	—	39%	+	22,000
Mendocino, Lake	13%	NS	48%	NS	29%	NS	36,000
Tehama, Glenn, Colusa	15%	NS	33%	NS	44%	+	31,000
Sutter, Yuba	***	***	45%	NS	39%	NS	44,000
Nevada, Plumas, Sierra	***	***	51%	NS	23%	NS	26,000
Tuolumne, Inyo, Calaveras, Amador, Mariposa, Mono, Alpine	***	***	52%	NS	24%	NS	40,000
Greater Bay Area	7.1%	NS	64.6%	—7.2	17.8%	+3.5	1,733,000
Santa Clara	6%	NS	64%	NS	20%	NS	455,000
Alameda	9%	NS	60%	—	22%	NS	378,000
Contra Costa	***	***	69%	NS	14%	NS	277,000
San Francisco	***	***	58%	NS	26%	NS	122,000
San Mateo	***	***	72%	NS	***	***	181,000
Sonoma	***	***	66%	NS	14%	NS	114,000
Solano	6%	NS	66%	—	15%	NS	120,000
Marin	***	***	67%	NS	***	***	52,000
Napa	14%	NS	61%	NS	15%	NS	33,000
Sacramento Area	6.9%	NS	60.7%	—9.8	22.5%	+6.1	540,000
Sacramento	***	***	56%	—	28%	+	367,000

Source: 2003 and 2001-R California Health Interview Surveys
UCLA Center for Health Policy Research, December 2004
www.healthpolicy.ucla.edu

Placer	***	***	73%	NS	***	***	79,000
Yolo	***	***	70%	NS	13%	NS	51,000
El Dorado	***	***	68%	NS	14%	NS	43,000
San Joaquin Valley	14.1%	NS	43.4%	NS	36.2%	+5.2	1,179,000
Fresno	17%	NS	41%	NS	38%	NS	281,000
Kern	13%	NS	42%	NS	41%	+	237,000
San Joaquin	17%	NS	54%	NS	22%	NS	211,000
Stanislaus	11%	NS	49%	NS	26%	NS	155,000
Tulare	11%	NS	35%	NS	51%	+	133,000
Merced	19%	NS	34%	—	41%	+	81,000
Kings	8%	—	44%	NS	43%	+	41,000
Madera	11%	NS	39%	NS	41%	NS	40,000
Central Coast	10.4%	—7.0	52.0%	—5.9	27.0%	+8.8	595,000
Ventura	***	***	56%	NS	28%	+	235,000
Santa Barbara	16%	NS	50%	NS	25%	NS	104,000
Santa Cruz	11%	NS	51%	NS	26%	NS	66,000
San Luis Obispo	***	***	42%	—	36%	+	55,000
Monterey, San Benito	15%	NS	52%	NS	25%	NS	135,000
Los Angeles	11.3%	—6.5	46.1%	NS	35.8%	+4.8	2,893,000
Los Angeles	11%	—	46%	NS	36%	+	2,893,000
Other Southern California	13.5%	—2.6	48.9%	—5.2	27.8%	+4.9	2,780,000
Orange	13%	NS	50%	—	26%	+	823,000
San Diego	15%	NS	52%	—	24%	NS	777,000
San Bernardino	12%	NS	42%	NS	36%	NS	603,000
Riverside	14%	NS	51%	NS	25%	NS	528,000
Imperial	14%	—	33%	NS	44%	NS	49,000

*** The estimate is not statistically stable (coefficient of variation is over 30%).
Note: — = decline since 2001, + = increase since 2001, NS = no significant change since 2001
Rates of privately purchased insurance, other government programs, and combinations of insurance are not reported.
CHIS 2001 estimates based on CHIS 2001-R data file (reweighted).

Source: 2003 and 2001-R California Health Interview Surveys
UCLA Center for Health Policy Research, December 2004
www.healthpolicy.ucla.edu

Attachment II:

Open Enrollment 2005 Survey Report

MAXIMUS

Open Enrollment 2005

Summary Report

Open Enrollment 2005 Summary Report

Subscribers with Option to change plans at 2005 OE **Total = 727,290**	Subscribers Who Voluntarily Changed plans	% of Total	Subscribers Who Were Required* to Change Plans	% of Total	Sub-Total Subscribers That Changed During OE	% of Total	Total Subscribers That Changed During OE	% of Total
Subscribers Changing Only Health Plans	**12,621**	**1.74%**	**1,422**	**0.20%**	**14,043**	**1.93%**	**17,521**	**2.41%**
Subscribers Changing Only Dental Plans	**10,363**	**1.42%**	**203**	**0.03%**	**10,566**	**1.45%**	**14,044**	**1.93%**
Subscribers Changing Vision Plans	**2,354**	**0.32%**			**2,354**	**0.32%**	**2,354**	**0.32%**
Subscriber Changing Both Health and Dental Plans	**3,405**	**0.47%**	**73**	**0.01%**	**3,478**	**0.48%**		

* Indicates subscribers whose plan was no longer available in their zip code and they did not select a plan on their own.
* Does not include the transfers from Sharp to Molina or from Universal Care to Molina in June of 2005.

Open Enrollment Historical Data

	1999	% of Total	2000	% of Total	2001	% of Total	2002	% of Total	2003	% of Total	2004	% of Total
Subscribers Changing Health Plans	3,827	3.00%	10,326	4.00%	14,566	3.00%	16,485	3.00%	*		36,903	6.00%
Subscribers Changing Dental Plans	3,875	3.00%	8,005	3.00%	22,031	5.00%	12,142	2.00%	*		11,424	2.00%
Subscribers With Option to Change Plans at OE **Total**	113,083		293,978		434,346		555,890		*		663,845	

Data includes voluntary and required transfer request
* Data not available

Open Enrollment 2005 - Satisfaction Survey

5,973 people responded to the Satisfaction Survey. On a scale of 1-5 (5 meaning Extremely Satisfied and 1 meaning Not At All Satisfied) on average respondents indicated they were between satisfied and very satisfied with their Health Plan (3.7) and Vision Plan (3.7). Respondents indicated that they were satisfied with their Dental Plan (3.0).

Reasons Why Plan Transfers Were Requested

5,973 people responded to the Health Plan survey and 5,246 people responded to the Dental Plan Survey

Top Reasons

Health Plan Changes

1. Problem getting a doctor I'm happy with
2. Appointments to see the doctor have to be made too long in advance.
3. Doctor's office is too far away
4. Not satisfied with medical care received
5. Problem getting a specialist when I need one

Dental Plan Changes

1. Problem getting a Dentist I'm happy with
2. Appointments to see the dentist have to be made too long in advance.
3. Not satisfied with dental care received
4. Dentist's office is too far away
5. Not being able to see a dentist when the need is urgent

Open Enrollment 2005 Sharp and Universal Care Health Plan Movement Report

Original Health Plan	Subscribers Transferred to Molina	Number of Subscribers originally enrolled in Sharp Or Universal Care Who Transferred Out of Molina at OE	% of Total Originally Transferred
Sharp Health Plan	**20,532**	**1,271**	**6.19%**
Universal Care Health Plan	**3,351**	**199**	**5.94%**

Customer Satifaction Survey Historical Data
Open Enrollment 1999-2005

Survey Question	Response	Extremely Satisfied (5)		Between Very Satisfied and Extremely Satisfied (4.5)		Very Satisfied (4)		Between Satisfied and Very Satisfied (3.5)		Satisf (3)
		#	%	#	%	#	%	#	%	#
Question 1 "How satisfied are you with the level of service you have received from your Health Plan?"										
1999	*	*				*				*
2000	*	*				*				*
2001	4,780	*				*				*
2002	4,742	569	12%			863	18%			1,683
2003	6,785	793	12%			1,288	19%			2,568
2004	4,998	741	15%			1,035	21%			1,966
2005	12,187	3,226	26%	13	0%	3,512	29%	10	0%	3,679
Question 4 "How satisfied are you with the level of service you have received from your medical group/clinic and the doctors and nurses who work there?"										
1999	*	*				*				*
2000	*	*				*				*
2001	4,559	*				*				*
2002	4,584	671	15%			871	19%			1,598
2003	6,550	841	13%			1,266	19%			2,323
2004	4,839	768	16%			1,034	21%			1,715
2005	11,763	3,239	28%	8	0%	3,453	29%	11	0%	3,331
Question 2 "How satisfied are you with the level of service you have received from your Dental Plan?"										
1999	*	*				*				*
2000	*	*				*				*
2001	6,895	*				*				*
2002	4,683	299	6%			384	8%			1,045
2003	4,859	325	7%			461	9%			1,172
2004	2,714	279	10%			673	25%			143
2005	11,533	1,800	16%	5	0%	2,357	20%	11	0%	3,079
Question 3 "How satisfied are you with the level of service you have received from your Vision Plan?"										
1999										Question Not Included On Su
2000										Question Not Included On Su
2001	7,973	*				*				*
2002	9,743	2,857	29%			2,800	29%			3,526
2003	12,796	3,618	28%			3,935	31%			4,609
2004	6,336	1,646	26%			1,932	30%			2,358
2005	10,145	2,624	26%	3	0%	3,010	30%	8	0%	3,796

Legend

* Data is not available
1999-2000 data included voluntary and required transfer requests
2001-2003 data included voluntary transfer requests only (except Vision Question)

Health Plan Change Reasons Historical Data
Open Enrollment 1999-2005

Note - Applicant may have indicated more than one reason. Data includes voluntary and required transfer requests.

	1999		2000		2001		2002		2003		2004		2005	
Reason	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases
Problem getting a doctor I'm happy with*	125	25%	719	20%	987	13%	1,555	14%	2,843	13%	1,552	11%	3,173	11%
Problem getting a specialist when I need one*	36	7%	279	8%	520	7%	923	8%	1,771	8%	1,027	7%	1,881	7%
Problem getting care that I or my doctor believed to be necessary	**	**	**	**	357	5%	604	5%	1,018	5%	587	4%	1,533	6%
Not satisfied with medical care received*	75	15%	719	20%	716	10%	1,090	10%	2,068	9%	1,320	9%	1,900	7%
Primary care doctor left the plan	63	13%	201	6%	403	5%	610	5%	1,243	6%	710	5%	1,099	4%
Appointments to see the doctor have to be made too long in advance.	63	13%	591	16%	651	9%	1,153	10%	1,827	8%	1,092	7%	3,085	11%
Two weeks	**	**	**	**	**	**	**	**	725	3%	352	2%	1,458	5%
Three weeks	**	**	**	**	**	**	**	**	400	2%	284	2%	866	3%
Four weeks or more	**	**	**	**	**	**	**	**	702	3%	456	3%	761	3%
Not being able to see a doctor when the need is urgent	**	**	**	**	723	10%	1,191	10%	2,457	11%	1,481	10%	1,875	7%
Not satisfied with the hours or days a primary care doctor's office is open*	18	4%	382	11%	350	5%	479	4%	1,351	6%	945	6%	1,324	5%
Problem getting help or advice during regular office hours	**	**	**	**	358	5%	616	5%	1,257	6%	819	6%	1,335	5%
I need an interpreter but doctor's office does not have one*	29	6%	124	3%	120	2%	172	2%	265	1%	232	2%	476	2%
Doctor's office is too far away. Check One:	67	14%	440	12%	507	7%	707	6%	1,298	6%	788	5%	2,077	8%
1-5 miles	**	**	**	**	74	1%	81	1%	219	1%	130	1%	837	3%
6-10 miles	**	**	**	**	136	2%	210	2%	384	2%	239	2%	587	2%
10 miles or more	**	**	**	**	293	4%	416	4%	695	3%	419	3%	653	2%
Children are discriminated against because they are enrolled in Healthy Families	18	4%	131	4%	132	2%	204	2%	316	1%	203	1%	526	2%
It took too long to receive laboratory results and diagnosis	**	**	**	**	**	**	**	**	**	**	315	2%	1,103	4%
Two weeks	**	**	**	**	**	**	**	**	**	**	98	1%	608	2%
Three weeks	**	**	**	**	**	**	**	**	**	**	85	1%	246	1%
Four weeks or more	**	**	**	**	**	**	**	**	**	**	132	1%	249	1%
I do not like the condition of the doctor's office	**	**	**	**	**	**	**	**	**	**	722	5%	1,129	4%
I did not agree with the course of treatment	**	**	**	**	**	**	**	**	**	**	383	3%	827	3%
Authorization for a medical treatment was denied	**	**	**	**	**	**	**	**	**	**	201	1%	502	2%
Medication not covered by the plan	**	**	**	**	**	**	**	**	**	**	396	3%	821	3%
Not satisfied with the hospital network available	**	**	**	**	**	**	**	**	**	**	435	3%	662	2%
Not satisfied with customer service at the plan level	**	**	**	**	**	**	**	**	**	**	438	3%	669	2%
Optional benefits not available	**	**	**	**	**	**	**	**	**	**	181	1%	391	1%
Other	**	**	**	**	1,086	15%	1,446	13%	4,533	20%	829	6%	1,283	5%
Total	494	100%	3,586	100%	6,906	100%	10,750	100%	22,247	100%	14,656	100%	27,671	100%

Legend

* In 2001 the wording of the question changed. The meaning is generally the same.

** The question was not included in that year's survey.

Attachment III:

Healthy Families Program 2004 Report of Consumer Survey of Health Plans

Healthy Families Program
2004 Report of Consumer Survey of Health Plans

March 2004
Data Insights Report No. 19

Table of Contents

2004 Report of Consumer Survey of Health Plans

This report summarizes results from the fourth annual consumer satisfaction survey for the Healthy Families Program (HFP). This survey is a key component of the quality monitoring activities for the program. In addition to being an important tool in monitoring quality and access to services HFP subscribers experience with their health plans, subscribers receive this information during the Open Enrollment period and in the program handbook which gives them additional facts about their health plan choices.

SURVEY METHODOLOGY

MRMIB conducted the survey through an independent survey vendor, DataStat, Inc., using the Child Medicaid version of the Consumer Assessment of Health Plan Survey (CAHPS®) 3.0H questionnaire[1]. The questionnaire contained 76 questions pertaining to nine aspects of care: access to care, customer service, communication of providers, and quality and satisfaction of health plan services and health care received. Responses to the questions have been summarized into four global ratings and five composite scores. The global ratings included ratings of health plan, health care, regular doctor or nurse, and specialist. The composite scores addressed getting needed care, getting care quickly, how well doctors communicate, helpfulness and courteousness of doctor's office staff and customer service. The survey also contained a module for examining the experiences of subscribers with chronic medical conditions. Details of this module are presented on page 20.

DataStat, Inc. conducted the survey over an 8-week period using a mixed mode (telephone and mail) five-step protocol between September and December 2003. Telephone follow-up was conducted for non-respondents in English and Spanish only. The protocol for conducting the telephone follow-up in the Asian languages has not been developed. DataStat, in consultation with MRMIB staff, developed the pre-notification and follow-up letters based on recommended samples from the CAHPS® 3.0H protocol.

The survey was conducted in five languages--English, Spanish, Cantonese, Korean and Vietnamese. The instruments in the Asian languages were made available for use through the support of the California Medi-Cal Policy Institute in 2000. Families selected for the survey received the survey in English, and Spanish, Cantonese, Korean or Vietnamese if one of these languages was designated as the primary language on the families' HFP application.

[1] CAHPS® 3.0H comes from the Health and Employer Data Information Set (HEDIS) produced by the National Committee for Quality Assurance (NCQA).

Nine-hundred families per health plan were sampled for the survey. This was a decrease in the number of families surveyed last year and reflects changes made to the CAHPS® survey protocol. Last year the survey protocol required 1,050 families to be surveyed for the Medicaid and commercial surveys. The sample size for these surveys was determined by the minimum number of returned surveys needed for the analysis and the expected response rates. Because the response rates for the Medicaid surveys have been low historically, NCQA increased the sample size for Medicaid surveys from 1,050 to 1,650. On the contrary, the sample size for the commercial surveys was reduced from 1,050 to 900 because commercial survey response rates have been high historically. Since response rates for the HFP surveys have been comparable to commercial response rates, MRMIB used the sample size recommended for the commercial surveys.

Twenty-one plans had sufficient HFP enrollment to provide the target sample. For the four plans that did not have sufficient enrollment, all subscribers in these plans who met the age and continuous enrollment criteria were surveyed. The number of families who were selected for the survey and the distribution of language surveys for each participating health plan is presented in Table 1.

Table 1 – Distribution of Surveys in Each Language Group by Health Plan

Health Plan	Total	E	S	C	K	V
Alameda Alliance for Health	900	377	387	105	2	29
Blue Cross - EPO	900	512	376	3	7	2
Blue Cross - HMO	900	450	346	40	50	14
Blue Shield - EPO	900	736	156	1	5	2
Blue Shield - HMO	900	542	272	23	42	21
CalOptima	900	177	608	1	32	82
Care 1st Health Plan	900	196	698	3	1	2
Central Coast Alliance for Health	639	148	489	1	1	0
Community Health Group	900	247	646	1	0	6
Community Health Plan	900	228	621	30	9	12
Contra Costa Health Plan	900	242	648	4	2	4
Health Net	900	528	332	19	6	15
Health Plan of San Joaquin	900	413	479	4	0	4
Health Plan of San Mateo	712	177	533	1	1	0
Inland Empire Health Plan	900	333	560	1	0	6
Kaiser Permanente	900	567	316	7	4	6
Kern Family Health Care	900	390	506	0	2	2
Molina	900	234	662	0	2	2
San Francisco Health Plan	900	275	178	444	1	2
Santa Barbara Regional Health Authority	704	180	524	0	0	0
Santa Clara Family Health Plan	900	189	531	7	2	171
Sharp Health Plan	900	459	428	1	2	10
UHP Healthcare	760	253	443	21	38	5
Universal Care	900	242	642	1	4	11
Ventura County Health Plan	900	174	726	0	0	0
Total	**21,715**	**8,269**	**12,107**	**718**	**213**	**408**

E= English S=Spanish C=Cantonese K=Korean V=Vietnamese

As shown in Table 1, most of the surveys were distributed in English and Spanish. Although Cantonese, Korean and Vietnamese surveys comprised 6 percent of the total sample, for 2 plans (Alameda Alliance for Health and San Francisco Health Plan) these languages comprise 15 percent and 50 percent respectively.

In 2000, an oversampling of families who received the survey in Chinese, Vietnamese and Korean showed that families responding in these languages rated the various factors less favorably than families responding in English and Spanish. These differences in responses among language groups may affect the scores of San Francisco Health Plan and Alameda Alliance for Health with a large number of subscribers whose primary language is one of the Asian languages. Regarding the Spanish and English speaking respondents, prior research has shown that responses to the CAHPS® survey from both language groups are not different.

One area that MRMIB continues to explore is the differences in survey responses among the five language groups. RAND has received results from previous HFP health surveys for analysis and will submit the findings to MRMIB upon completion.

SURVEY RESULTS: OVERALL RATINGS

All plans had an adequate number of returned surveys to permit the analysis for plan-to-plan comparisons. The minimum number of responses needed for the analysis was 411 completed surveys per plan, which is the target number that NCQA defines for accreditation purposes. This goal allows for at least 100 responses per question for a comparative analysis and is comparable to most types of statistical testing. The following pages contain the HFP program and individual plan survey results for overall ratings and composites. Also included are new areas of analysis showing the areas of strongest and weakest performance and the items most highly correlated with satisfaction.

Summary of Responses

The responses to the survey are summarized into four rating and five composite questions. Responses that indicate a positive experience were considered achievement scores.

Rating Questions Responses: For the four rating questions, a 10-point scale was used to assess overall experience with health plans, health care, providers, and specialists. For this scale, "0" represents the worst and "10" represents the best. The achievement scores for these questions were determined by the percentage of families responding to each question using an 8, 9 or 10 rating. Individual plan scores for the 2003 survey are compared with the overall program score in 2003 and 2002 and a *benchmark*. This benchmark is based on the highest score achieved by a participating health plan with a minimum of 75 responses.

A large majority of HFP families gave their *Health Care, Health Plan, Personal Doctor (or Nurse) and Specialist* a high rating (at least an 8 on a 10 point scale). The rating of *Health Plan* had the highest achievement score for 2003 (86 percent). The rating of *Health Plan* also had the highest achievement score for 2002. Although the 2003 score (86 percent) was slightly lower than the 2002 score (87 percent), the differences in scores were not statistically significant.

The rating of *Specialist* had the lowest achievement score for 2003. The rating of *Specialist* also had the lowest achievement score for 2002. Although the 2003 score (79 percent) was slightly lower than the 2002 score (80 percent), the differences in scores were not statistically significantly different. Note that most plans had less than the desired responses to draw firm conclusions about the rating of *Specialist*.

The percentage of families rating their *Personal Doctor or Nurse* an 8, 9, or 10 ***increased*** from 2002 (80 percent) to 2003 (82 percent). This change was statistically significant. The percentage of families rating their *Health Care* an 8, 9, or 10 decreased from 2002 (81 percent) to 2003 (80 percent). This change was not statistically significant.

Of the scores achieved by individual plans, the highest score was achieved by Inland Empire Health Plan for overall rating of *Specialist* (98 percent). The lowest score obtained was by San Francisco Health Plan for the overall rating of *Specialist* (58 percent). Blue Cross EPO, Kaiser Permanente and Santa Barbara Regional Health Authority had achievement scores that were significantly above the program average in three of the four rating questions. Community Health Plan and San Francisco Health Plan had achievement scores that were significantly below the average in three to four rating questions.

Table 2 shows whether the plan results for the ratings questions were statistically significantly above or below the program average.

Table 2 – Statistically Significantly Higher and Lower than HFP Overall Ratings Scores

Health Plan	Overall Health Plan	Overall Health Care	Overall Personal Doctor or Nurse	Overall Specialist
Alameda Alliance for Health	▼		▼	
Blue Cross – EPO	▲	▲	▲	
Blue Cross – HMO	▼			
Blue Shield – EPO		▲	▲	
Blue Shield – HMO	▼			
CalOptima				
Care 1st Health Plan	▼			
Central Coast Alliance for Health	▲		▲	
Community Health Group				
Community Health Plan	▼	▼	▼	
Contra Costa Health Plan				
Health Net				
Health Plan of San Joaquin	▲	▲		
Health Plan of San Mateo				▲
Inland Empire Health Plan	▲			▲
Kaiser Permanente	▲	▲	▲	
Kern Family Health Care				
Molina				
San Francisco Health Plan	▼	▼	▼	▼
Santa Barbara Regional Health Authority	▲	▲		▲
Santa Clara Family Health Plan	▲			
Sharp Health Plan	▲		▲	
UHP Healthcare	▼		▼	
Universal Care				
Ventura County Health Plan		▲	▲	

▲ = Statistically significantly higher than HFP Overall Rating Scores
▼ = Statistically significantly lower than HFP Overall Rating Scores

This table will show changes in plan scores that have increased or decreased 4 or more percentage points from 2002 to 2003.

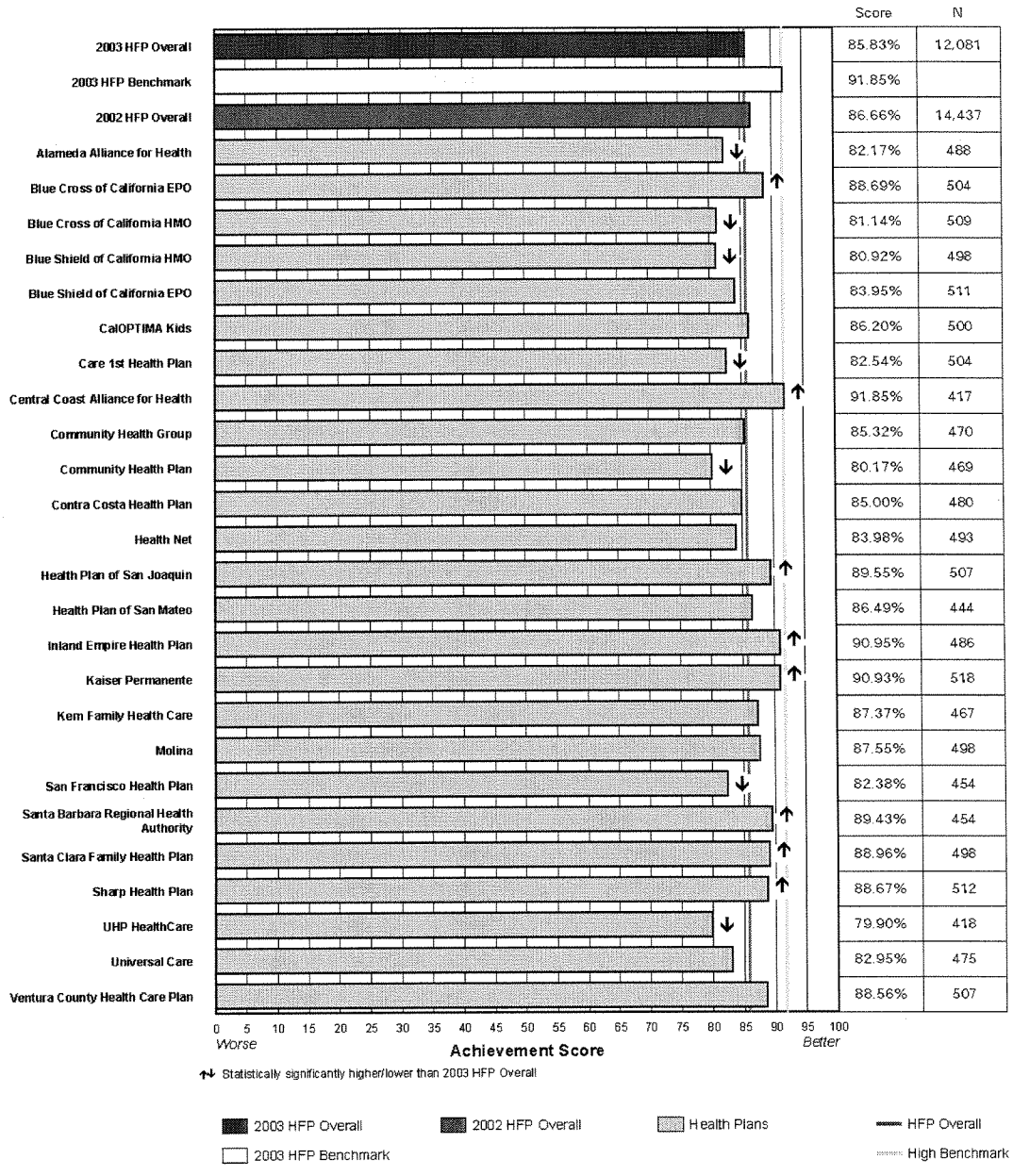
Table 3 – Plan Performance Changes in Overall Ratings 2002-2003

Health Plan	Overall Health Plan	Overall Health Care	Overall Personal Doctor or Nurse	Overall Specialist
Alameda Alliance for Health				↓ (9%)
Blue Cross – EPO		↓ (4%)		↓ (4%)
Blue Cross – HMO		↑ (4%)	↑ (9%)	↑ (8%)
Blue Shield – EPO	↓ (5%)	↑ (8%)	↓ (5%)	↓ (6%)
Blue Shield – HMO		↓ (8%)	↑ (15%)	↓ (6%)
CalOptima		↓ (4%)		↓ (4%)
Care 1st Health Plan			↑ (4%)	↑ (6%)
Central Coast Alliance for Health	↑ (5%)		↑ (7%)	
Community Health Group	↓ (5%)	↓ (4%)		
Community Health Plan	↓ (4%)	↓ (4%)	↓ (4%)	↓ (13%)
Contra Costa Health Plan				
Health Net				
Health Plan of San Joaquin			↑ (4%)	
Health Plan of San Mateo				↑ (6%)
Inland Empire Health Plan			↑ (4%)	↑ (17%)
Kaiser Permanente	↑ (4%)		↑ (4%)	
Kern Family Health Care		↓ (4%)		↓ (11%)
Molina				↑ (7%)
San Francisco Health Plan		↓ (4%)		↓ (15%)
Santa Barbara Regional Health Authority			↓ (4%)	
Santa Clara Family Health Plan				
Sharp Health Plan				
UHP Healthcare				↓ (10%)
Universal Care	↓ (6%)	↓ (5%)		↑ (6%)
Ventura County Health Plan				

Pages 6-9 present the individual scores for each plan for each rating.

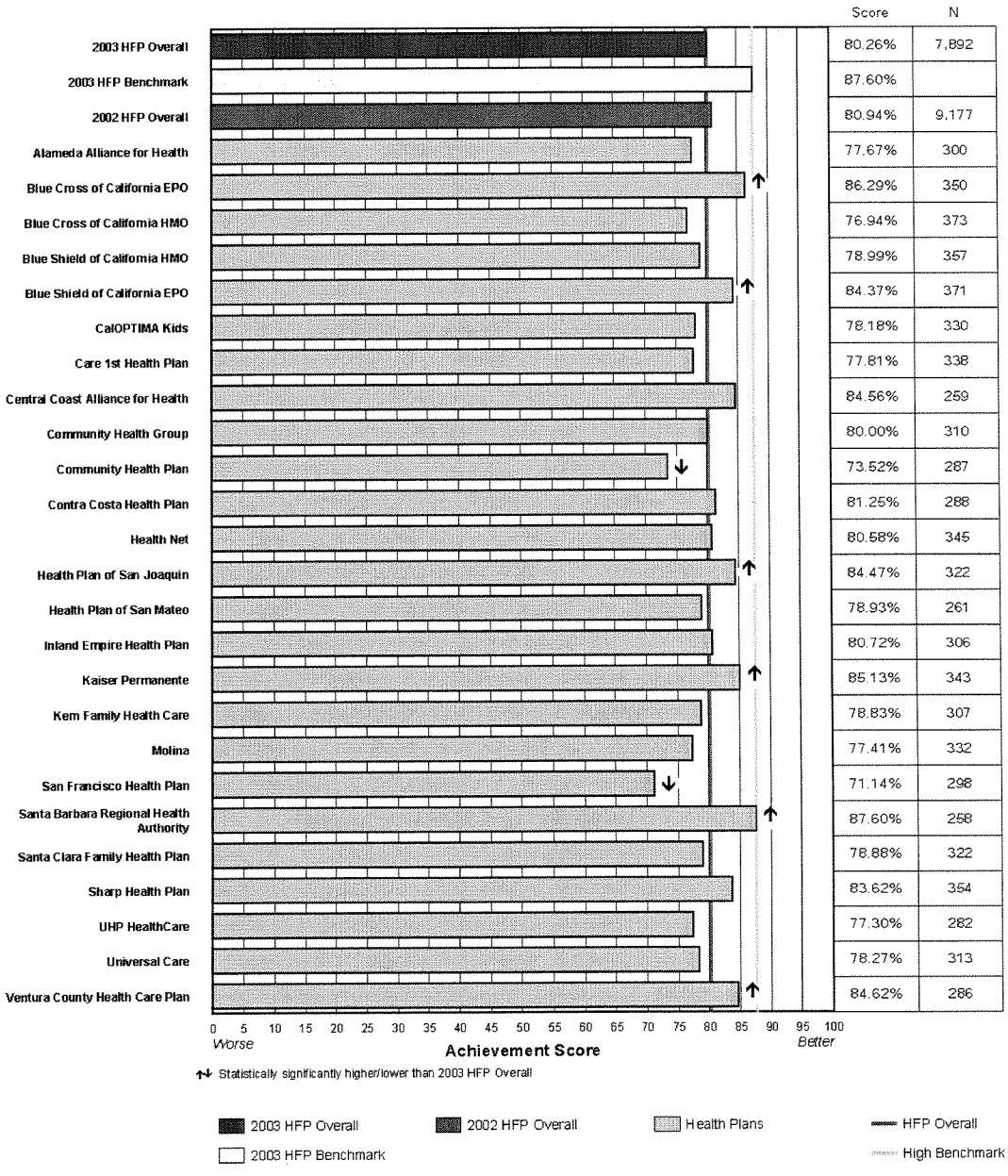
Overall Ratings (8, 9, 10)

Q62. Overall rating of health plan



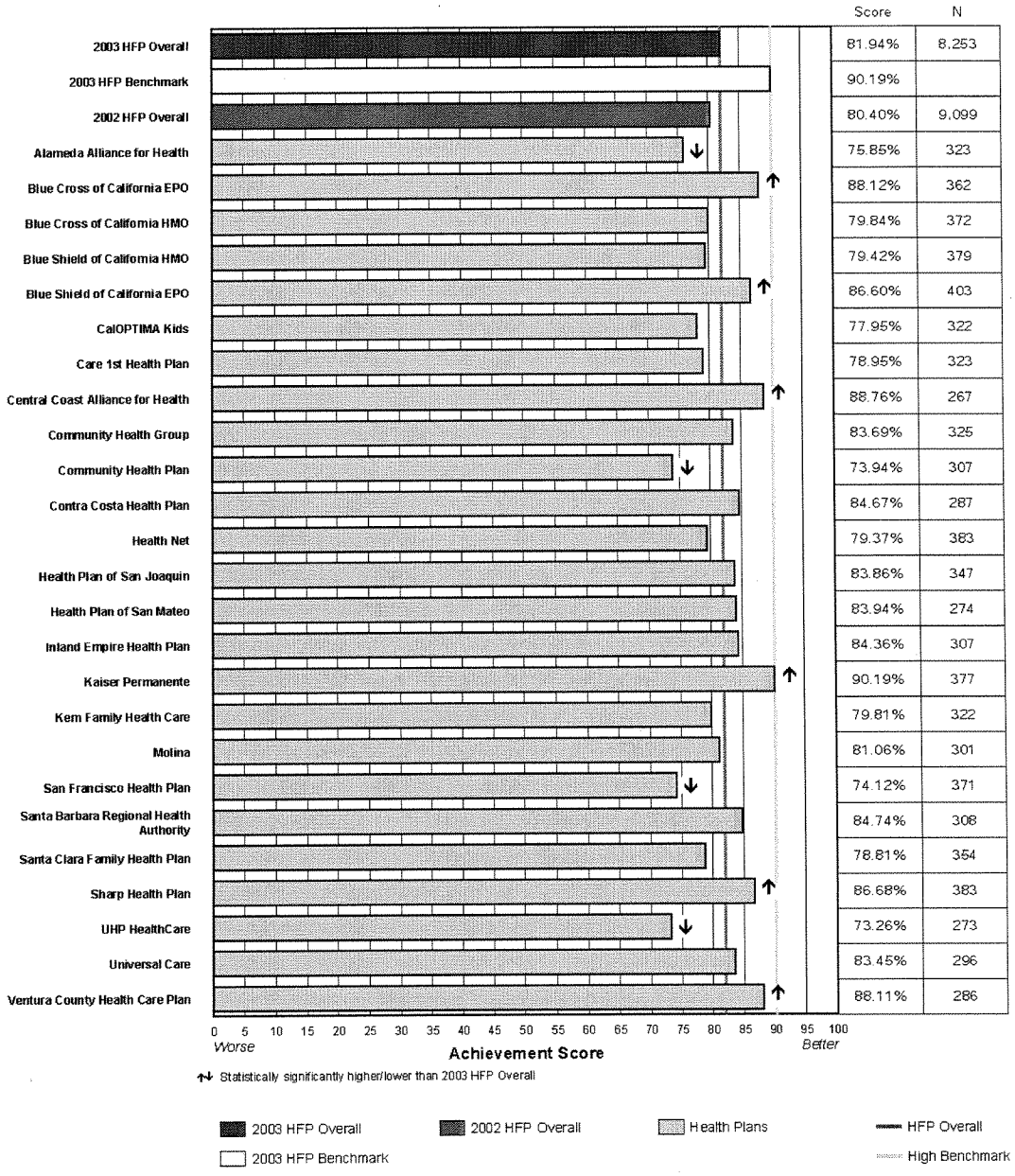
Overall Ratings (8, 9, 10)

Q39. Overall rating of health care



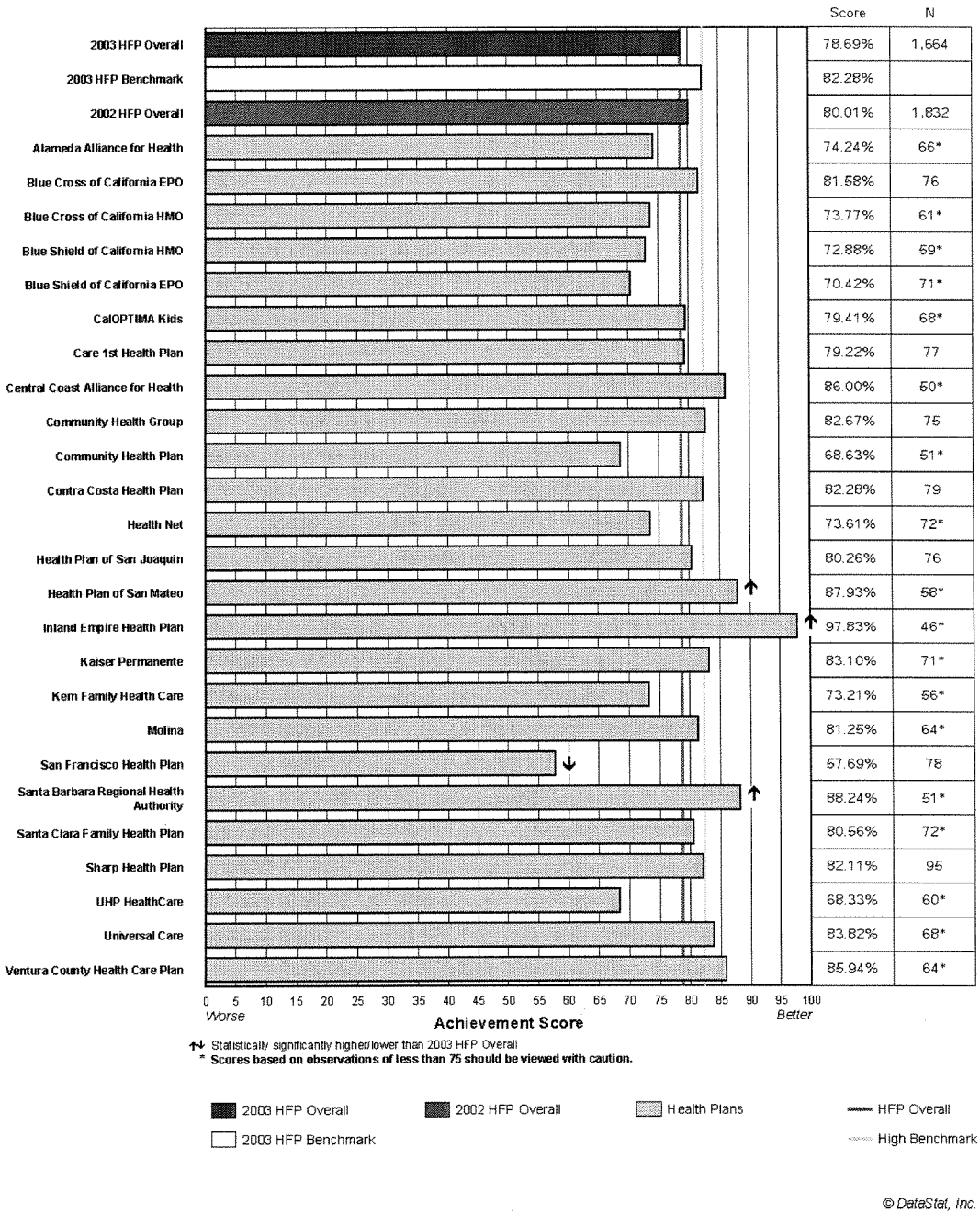
Overall Ratings (8, 9, 10)

Q5. Overall rating of personal doctor or nurse



Overall Ratings (8, 9, 10)

Q12. Overall rating of specialist



SURVEY RESULTS: COMPOSITE SCORES

Composite Score Results: For the composite score, questions that are related to the same broad domain of performance are grouped. For example, *Getting Care Quickly* includes questions about getting advice by phone, about how soon appointments were scheduled, and about time spent waiting in the doctor's office. The achievement score for each composite is determined by the percentage of families who respond positively to each question that comprises the composite. A response is considered positive if the answers are "not a problem" for the questions comprising the *Getting Needed Care* and *Customer Service* composites, and "usually" and "always" for the *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff* composites.

The survey questions that comprise each composite score are listed below.

"Getting Needed Care"

- Able to get a personal doctor or nurse for child you are happy with
- Able to get a referral to a specialist for child
- Able to get the care for child believed necessary
- No problems with delays in child's health care while awaiting approval

"Getting Care Quickly"

- Usually or always got help of advice needed of child
- Child usually or always got an appointment for routine care as soon as wanted
- Child usually or always got needed care for an illness/injury as soon as wanted
- Child never or sometimes waited more than 15 minutes in the doctor's office or clinic

"How Well Doctor's Communicate"

- Doctors usually or always listened carefully
- Doctors usually or always explained things in an understandable way
- Doctors usually or always showed respect
- Doctors usually or always spent enough time with child

"Courteous and Helpful Office Staff"

- Usually or always treated with courtesy and respect by office staff
- Office staff usually or always helpful

"Customer Service"

- Able to find or understand information in written materials
- Able to get help needed when you called child's health plan's customer service

Meaningful differences in the composite scores from one year to the next are more appropriately evaluated by examining changes in the scores of the individual questions that make up each composite score rather than testing for statistical significance. Second, trend analysis in the area of *Getting Needed Care* and *Getting Care Quickly* is not possible due to revisions to the earlier CAHPS® 2.0H survey instrument. The revisions to the CAHPS® 2.0H survey that were incorporated in the 3.0H version included the insertion of additional questions, changes to response options of existing questions, and changes in skip patterns. These revisions changed the interpretation of the composites which makes comparing the 2.0H and 3.0H versions inappropriate.

The results of the survey indicated that at least 80 percent of families responded positively to all but two composite questions. The composite rating of *How Well Doctor's Communicate* had the highest number of positive responses for 2003 (87 percent). This was also the case for 2002 (88 percent). The two composite ratings that had less than 80 percent of families responding positively were *Getting Care Quickly* and *Customer Service.* The composite rating for *Getting Care Quickly* had the lowest achievement score for 2003 (63 percent) and for 2002 (70 percent).

With respect to individual health plan scores, Blue Shield of California EPO achieved the highest composite score of all composite scores among the plans. Ninety-four percent of Blue Shield EPO subscribers responded positively to *How Well Doctor's Communicate.* San Francisco Health Plan achieved the lowest composite score of all composite scores among the plans. Fifty-four percent of their subscribers responded positively to the *Getting Care Quickly* composite.

There were 4 health plans (Blue Cross EPO, Central Coast Alliance for Health, Kaiser Permanente and Santa Barbara Regional Health Authority) that had composite scores that were statistically significantly above the program average. There were also 2 plans (Community Health Plan and San Francisco Health Plan) that had composite scores statistically significantly below the program average. Table 4 shows for each plan which composite scores fell significantly above or below the program average.

Table 4 - Statistically Significantly Higher and Lower than HFP Overall Composite Scores

Health Plan	Getting Needed Care	Getting Care Quickly	How Well Doctors Commun -icate	Courteous & Helpful Office Staff	Customer Service
Alameda Alliance	▼				
Blue Cross – EPO	▲	▲	▲	▲	
Blue Cross – HMO		▼			
Blue Shield – EPO		▲	▲	▲	▼
Blue Shield – HMO	▼	▲		▲	
CalOptima	▼				
Care 1st Health Plan		▼	▼		
Central Coast Alliance for Health	▲	▲	▲	▲	
Community Health Group					
Community Health Plan	▼	▼	▼	▼	▼
Contra Costa Health Plan					
Health Net		▲			
Health Plan of San Joaquin				▲	
Health Plan of San Mateo					
Inland Empire Health Plan					
Kaiser Permanente	▲	▲	▲	▲	
Kern Family Health Care		▼	▼	▼	▲
Molina		▼	▼	▼	▲
San Francisco Health Plan	▼	▼	▼	▼	▼
Santa Barbara Regional Health Authority	▲	▲	▲	▲	
Santa Clara Family Health Plan					▲
Sharp Health Plan			▲		
UHP Healthcare					
Universal Care					
Ventura County Health Plan	▲		▲		

▲ = Statistically significantly higher than HFP Overall Rating Scores
▼ = Statistically significantly lower than HFP Overall Rating Scores

This table will show changes in plan scores that have increased or decreased 4 or more percentage points from 2002 to 2003.

Table 5 - Plan Performance Changes in Overall Composite Scores 2002-2003

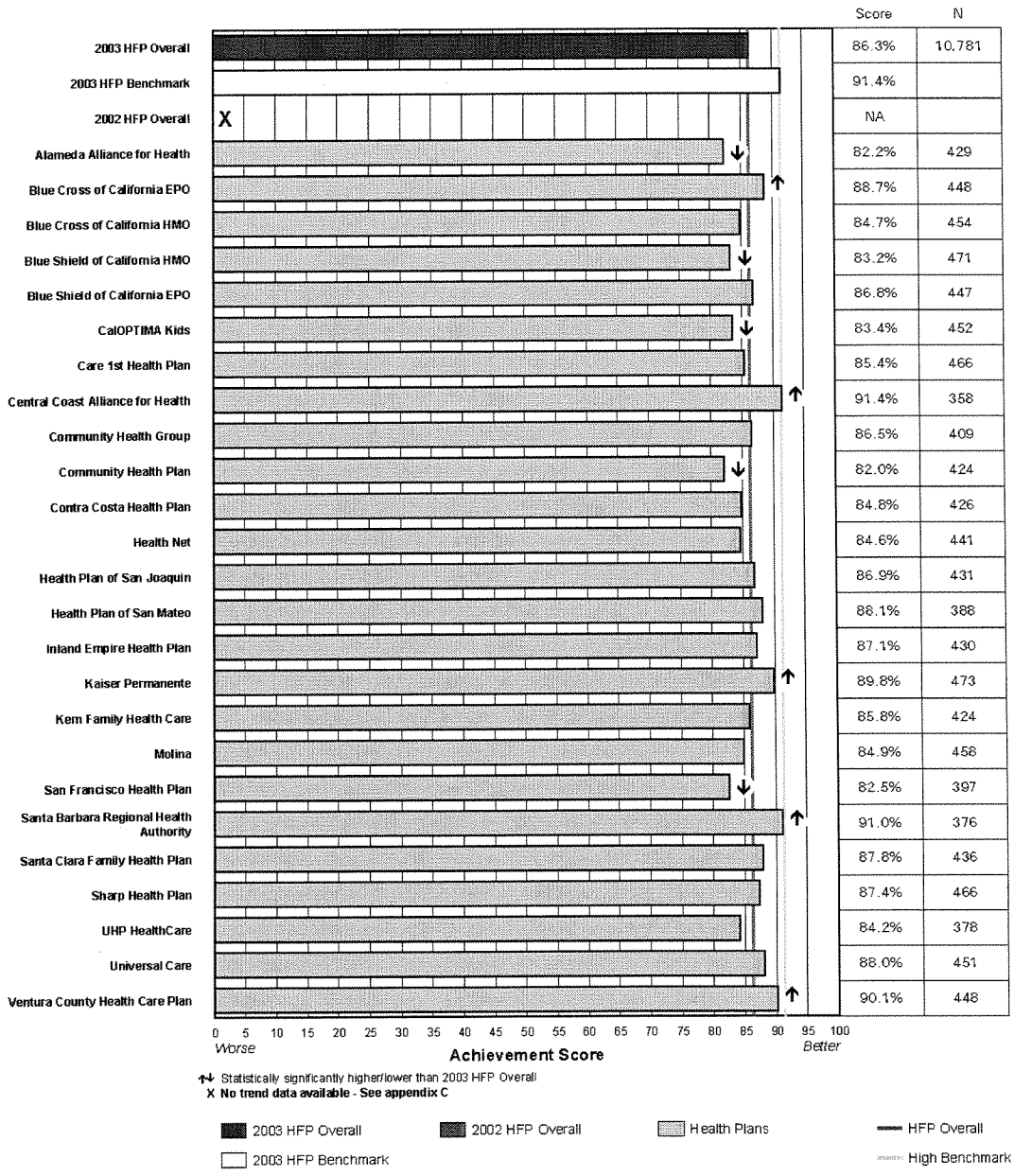
Health Plan	Getting Needed Care*	Getting Care Quickly*	How Well Doctors Communicate	Courteous & Helpful Office Staff	Customer Service
Alameda Alliance for Health					↓ (5%)
Blue Cross – EPO					↓ (6%)
Blue Cross – HMO					
Blue Shield – EPO				↓ (4%)	
Blue Shield – HMO			↑ (4%)	↑ (6%)	↓ (5%)
CalOptima					↓ (7%)
Care 1st Health Plan					↓ (7%)
Central Coast Alliance for Health				↑ (4%)	
Community Health Group					↓ (5%)
Community Health Plan				↓ (4%)	↓ (19%)
Contra Costa Health Plan				↑ (5%)	↓ (12%)
Health Net					↓ (6%)
Health Plan of San Joaquin					↓ (7%)
Health Plan of San Mateo					↓ (4%)
Inland Empire Health Plan			↓ (4%)		↓ (11%)
Kaiser Permanente					↓ (5%)
Kern Family Health Care			↓ (4%)	↓ (5%)	↓ (5%)
Molina					
San Francisco Health Plan				↓ (6%)	↓ (9%)
Santa Barbara Regional Health Authority					↓ (10%)
Santa Clara Family Health Plan				↑ (4%)	
Sharp Health Plan			↑ (4%)		↓ (11%)
UHP Healthcare					↓ (10%)
Universal Care					↓ (7%)
Ventura County Health Plan					↓ (10

**Trend analysis in the area of Getting Needed Care and Getting Care Quickly is not possible due to revisions to the earlier CAHPS® 2.0H survey instrument.*

The individual plan scores for all composites are shown on pages 14-18.

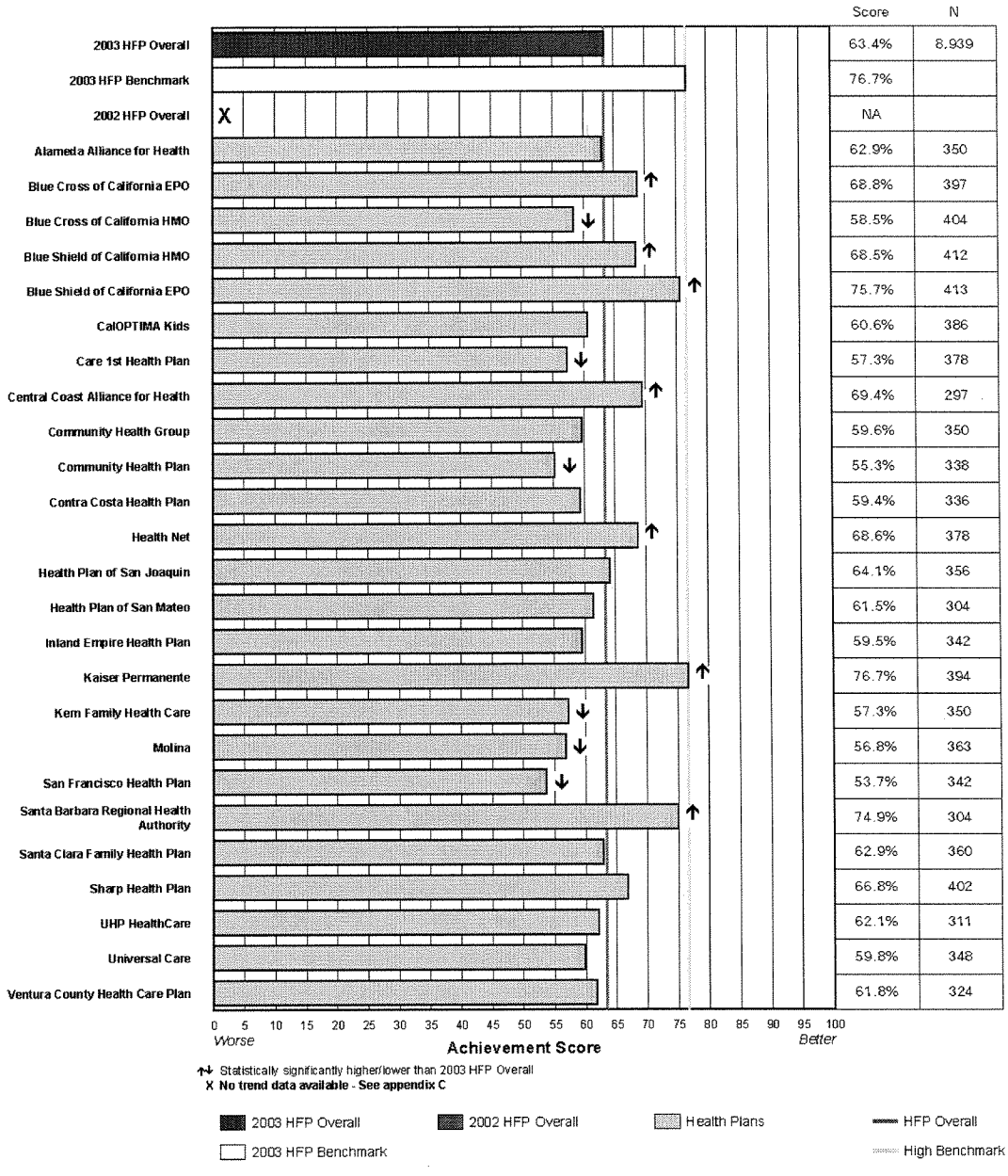
Getting Needed Care

Composite Score



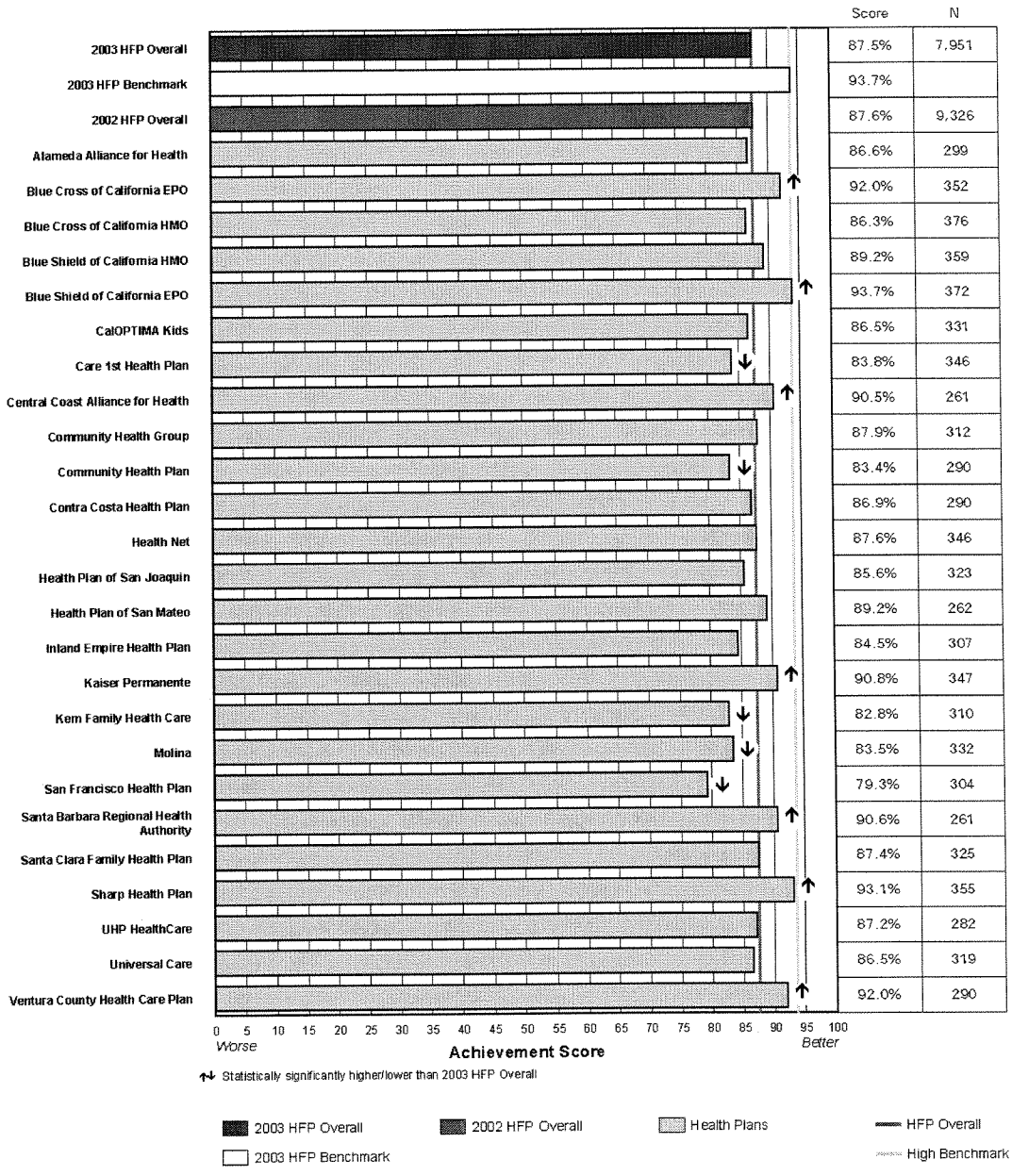
Getting Care Quickly

Composite Score



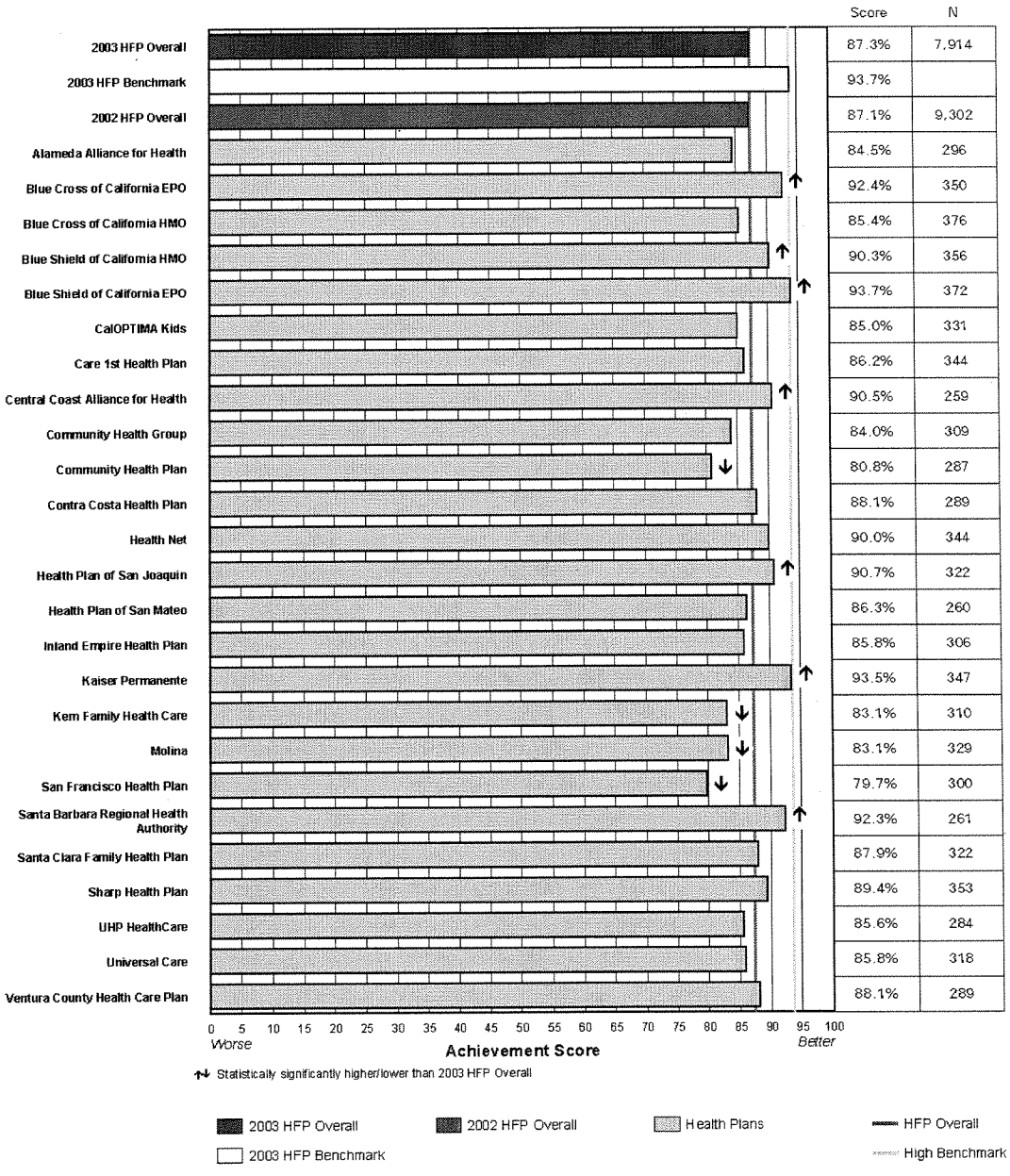
How Well Doctors Communicate

Composite Score



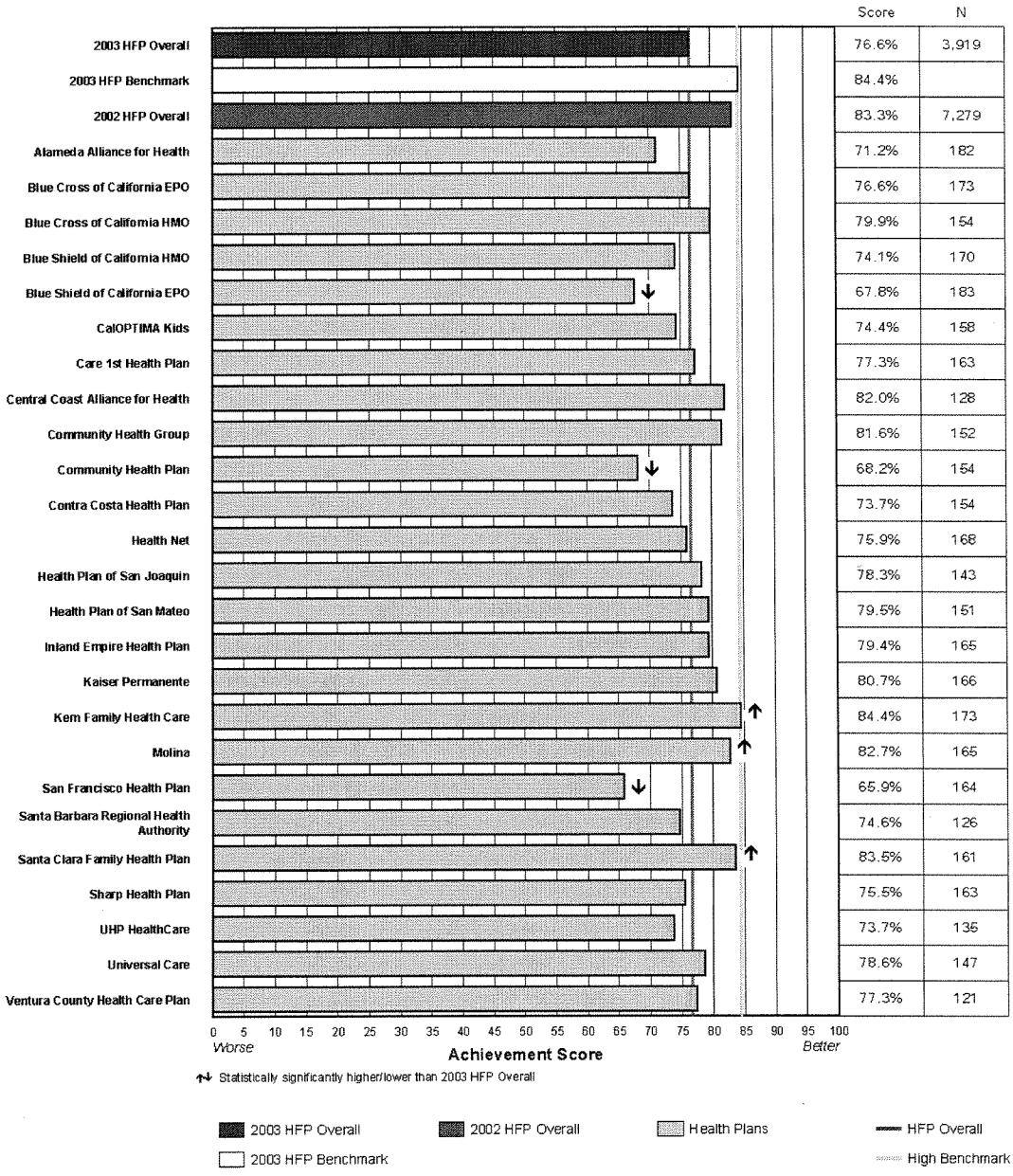
Courteous and Helpful Office Staff

Composite Score



Customer Service

Composite Score



SURVEY RESULTS: CORRELATION OF SCORES AND SATISFACTION

In addition to the overall and individual plan scores, DataStat, Inc. conducted three additional analyses to illustrate the program's strongest and weakest areas of performance and the top ten questions that were highly correlated with satisfaction. The areas of strongest and weakest performance are based on the highest and lowest achievement score for a particular question. Questions were identified as having a high positive performance if their achievement score was greater than or equal to 85 percent. There were five items that had over 90 percent of subscribers responding positively. All five items were not highly correlated with overall satisfaction. Questions were identified as having a low positive performance if their achievement score was lower than 85 percent. There were four items that had less than 85 percent of subscribers responding positively. In the areas of weakest performance, all items were highly correlated with satisfaction. Tables 6 and 7 outline the areas of strongest and weakest performance.

A correlation coefficient of 0.40 or greater indicates a relatively high correlation with plan satisfaction. Coefficients less than 0.40 indicate a low correlation with plan satisfaction.

Table 6 – Areas of Strongest Performance

Question	HFP Achievement Score	Correlation with overall Satisfaction (Yes or No)	Composite Group
No problem with paperwork for health plan	94.7%	N (0.16)	Single Item Measure*
No problems with delays in child's health care while waiting approval	93.6%	N (0.23)	Getting Needed Care
Did not call or write to health plan w/ complaint or problem	93.5%	N (0.17)	Single Item Measure*
Doctor usually or always showed respect	91.9%	N (0.31)	How Well Doctors Communicate
Doctors usually or always listened carefully	90.4%	N (0.33)	How Well Doctors Communicate

(*Single item measures are questions in the survey that do not fall into the ratings or composite group categories.)

Table 7 – Areas of Weakest Performance

Question	HFP Achievement Score	Correlation with overall Satisfaction (Yes or No)	Composite Group
Able to get help needed when you called child's health plan's customer service	73.3%	Y (0.45)	Customer Service
Overall rating of specialist	78.7%	Y (0.42)	Overall Ratings
Overall rating of health care	80.3%	Y (0.57)	Overall Ratings
Overall rating of personal doctor or nurse	81.9%	Y (0.45)	Overall Ratings

There were several other areas that were moderately correlated with satisfaction. These are shown in Table 8.

Table 8 – Other Items Correlated with Satisfaction

Question	HFP Achievement Score	Correlation with Satisfaction	Composite Group
Able to find or understand information in written materials	79.3%	.38	Customer Service
Able to get a personal doctor or nurse for child you are happy with	81.1%	.34	Getting Needed Care
Able to get referral to a specialist for child	64.4%	.34	Getting Needed Care
One week or less to resolve complaint	61.9%	.32	Single Item
Usually or always got help or advice needed for child	81.3%	.31	Getting Care Quickly

(Note: A correlation coefficient of 0.40 or greater indicates a relatively high correlation with plan satisfaction. Coefficients less than 0.40 indicate a low correlation with plan satisfaction.)

SURVEY RESULTS: SUBSCRIBERS WITH CHRONIC MEDICAL CONDITIONS

In addition to the general survey results presented in the previous section, MRMIB conducted a supplemental survey to assess the experiences subscribers with chronic medical conditions had with their health plans. This survey included the optional module in CAHPS® 3.0H for children with chronic conditions (CCC). This is the first time MRMIB has included this module in the consumer surveys.

The CAHPS® 3.0H CCC module contains 115 questions. Seventy-two questions address the same areas of member experience as CAHPS® 3.0H (access to care, customer service, communication of providers, and quality and satisfaction of health plan services and health care received). Forty-three questions address areas of experience that are relevant to children with chronic conditions. These areas include access to prescription medicines, access to specialized services, personal doctor or nurse who knows child, shared decision making, getting needed information and coordination of care. Also included in these 43 questions are "screener" questions that are used to identify children with chronic conditions.

For ease of administration, DataStat randomly selected a second sample of 2,225 children. A sample of 1,325 children was taken from children who were known to be receiving (or had received services) through the California Children's Services (CCS) program as of June 30, 2003. Children from CCS were selected because they have a chronic condition by virtue of being in the program. The remaining 900 children were randomly selected from the entire HFP population (who were not previously selected for the core survey) to comprise a control group representing the member experiences of the program as a whole. In the

HFP PedsQL® research 8.5 percent of HFP enrollees reported a chronic condition. The control group would likely have a similar percentage. The answers of those in the control group who were identified as having a chronic condition were included in the answers of the CCS children. This analysis does not break out the answers of chronically ill children in the control group from those in the CCS sample. There may be a sufficient number of them to do so in a future analysis. A program wide sample was drawn since most plans did not have a sufficient number of children enrolled in CCS meeting the CAHPS® survey criteria to conduct a plan to plan comparison. *For children in the CCS sample, it is not known whether their responses were due to experiences with their health plan or a combination of experiences with their health plan and the CCS program.*

Results from this supplemental survey were grouped into 3 categories; Overall Ratings, CAHPS® 3.0H Standard Composites and CAHPS® 3.0H Chronic Condition Composites. Responses from families identified as having a child with a chronic condition based on the "screener" questions were grouped into 2 categories – CCC and HFP.

Overall Ratings

Table 9 shows the achievement scores for the overall ratings for the CCC and the HFP population. There are negligible differences among the two groups in each category except for ratings of personal doctor or nurse. However, even with this difference most families gave their health plan, health care, personal doctor or nurse and specialist a high rating.

Table 9 – Overall Rating Achievement Scores for the CCC and HFP Populations

Overall Ratings (8,9, or 10)	CCC Achievement Scores	HFP Achievement Scores
Health Plan	86%	87%
Health Care	81%	82%
Personal Doctor or Nurse	86%	81%
Specialist	82%	80%

CAHPS® 3.0H Standard Composites

With respect to the composite scores, 2 of the composites had a slightly more favorable rating from the CCC population than from HFP population. These composites included *Getting Care Quickly* and *How Well Doctors Communicate*. The CCC population had a slightly lower level of favorable ratings for the other composites (*Courteous and Helpful Office Staff*, and *Customer Service*). There were major differences in scores between the two populations in the category of "*Getting Needed Care*". Table 10 shows the composite scores for the CCC and HFP population.

Table 10 – Standard Composite Scores for the CCC and HFP Populations

Overall Standard Composites	CCC Achievement Scores	HFP Achievement Scores
Getting Needed Care	79%	90%
Getting Care Quickly	68%	66%
How Well Doctors Communicate	89%	88%
Courteous & Helpful Office Staff	88%	89%
Customer Service	72%	76%

An additional comparison was done using a group of composite questions that specifically address the needs of the CCC population as developed for CAHPS® 3.0H. The differences in achievement score for the CCC and HFP populations varied with most scores being higher for the CCC and two score being slightly lower than the CCC. Table 11 shows the CCC composite scores for each population.

Table 11 – Chronic Condition Composite Scores for the CCC and HFP Populations

Question	CCC Achievement Scores	HFP Achievement Scores
Access to Prescription Medicines	92%	94%
Access to Specialized Services	80%	86%
Family Centered Care: Personal Doctor or Nurse Who Knows Child	80%	58%
Family Centered Care: Shared Decision Making	78%	75%
Family Centered Care: Getting Needed Information	81%	78%
Coordination of Care	68%	62%

Comparable data for the results obtained through the supplemental survey was not available through the 2003 National CAHPS® Benchmarking Database. Similar data was available through a study that was conducted by the Child and Adolescent Health Measurement Initiative (CAHMI) and the Oregon Health and Science University Department of Pediatrics. A comparison of HFP program results with the CAHMI study suggests that:
In 7 areas the CCC performed better than what was seen in the CAHMI study. The percentages appearing in the CAHMI study reflect the percentages of families responding positively who did and did not have a personal physician. A consolidated score from the CAHMI study was not available. The percentages for HFP include both. (See Table 12).

Table 12: Comparison of HFP and CAHMI Study Results for Children With and Without Chronic Conditions

Composite	2003 HFP Survey-CCC	2002 CAHMI Study-CCC	2003 HFP Survey-HFP	2002 CAHMI Study-Non-CCC
Getting Needed Care	79%	79.5%/67.0%	90%	89.5%/59.0%
Getting Care Quickly	68%	66.6%/54.9%	66%	70.6%/59.0%
Communication with Doctor	89%	80.3%/65.7%	88%	83.4%/71.6%
Access to Prescriptions	92%	74.8%/74.3%	94%	86.2%/85.7%
Access to Specialized Services	80%	65.1%/53.5%	86%	75.3%/73.5%
Access to Needed Information	81%	72.9%/53.8%	78%	79.7%/59.1%
Shared Decision Making	78%	67.8%/54.5%	75%	69.8%/62.1%
Coordination of Care	68%	66.5%/51.9%	62%	62.3%/52.1%

CONCLUSION

Results from this survey reveal key points regarding the Healthy Families Program.

1. Families continue to have positive experiences with their health plans. Eighty-six percent of families surveyed for the core survey gave their health plan high ratings (at least an 8 on a scale of 0-10). This is also true for the supplemental CAHPS® survey where 86 percent of children with CCC and 87 percent of the HFP gave their health plan high ratings (at least an 8 on a scale of 0-10).

2. The program's performance in the overall ratings compared to other programs (National SCHIP and National Medicaid)* were not substantially different. In two areas the program's performance was better than National SCHIP and National Medicaid results. There were 2 areas where the program's performance was slightly below National SCHIP and National Child Medicaid. (see Table 13).

Table 13 - Comparison of HFP, National SCHIP & National Child Medicaid for Ratings Questions

Rating Questions Definition of Achievement Scores (7,8,9,10)	2003 HFP	2003 National SCHIP	2003 National Child Medicaid
Health Plan	90%	85%	87%
Health Care	86%	91%	89%
Personal Doctor or Nurse	88%	90%	91%
Specialist	92%	89%	81%

*Comparison data taken from the 2003 National CAHPS® Benchmarking Database

3. With respect to the CAHPS® 3.0H standard composites, the program's performance was slightly above National SCHIP but under National
Medicaid Child Scores in 2 areas and below both National SCHIP and national Child Medicaid results in 3 areas. (see Table 14).

Table 14 - Comparison of HFP, National SCHIP & National Child Medicaid for Composite Questions

Composite Questions	Definition of Achievement Score	2003 HFP	2003 National SCHIP	2003 National Child Medicaid
Getting Needed Care	Not a Problem	86%	80%	92%
Getting Care Quickly	Usually + Always	63%	81%	78%
How Well Doctors Communicate	Usually + Always	88%	93%	90%
Courteous & Helpful Office Staff	Usually + Always	88%	96%	91%
Customer Service	Not a Problem	77%	72%	93%

4. In comparison to SCHIP and Medicaid scores, the HFP results for *Getting Care Quickly* (63 percent) and *Customer Service* (77 percent) draw attention to areas for future improvement. A future goal is to implement a quality improvement project that identifies best practices among participating health plans and facilitate improvement among plans with poor performance in these areas.

The data obtained from this survey provides plans and MRMIB with an opportunity to uncover areas of success and areas needing improvement. It also allows for an opportunity to compare California's SCHIP data to other SCHIP and Medicaid program data for a more global review. HFP health plans are provided with detailed information about their results which they have used to initiate changes in the delivery of services. At present, MRMIB is working with the plans to develop an approach to use the results from the survey for developing collaborative quality improvement activities for deficient areas, and for sharing best practices among participating health plans.

Acknowledgements
Prepared by Cristal Milberger, Benefits Specialist,
Assisted by Lorraine U. Brown, Deputy Director, Benefits and Quality Monitoring

Attachment IV:

Healthy Families Program 2004 Report of Consumer Survey of Dental Plans

Healthy Families Program

2004 Report of Consumer Survey of Dental Plans

March 2004

Data Insights Report No. 20

Table of Contents

2004 Report of Consumer Survey of Dental Plans

This report summarizes results from the third annual dental consumer satisfaction survey for the Healthy Families Program. This survey is a key component of the quality monitoring activities for the program. In addition to being an important tool in monitoring quality and access to services that HFP subscribers experience with their dental plans, subscribers receive this information during the Open Enrollment period and in the program handbook which gives them additional facts about their dental plan choices. To date, California is the only state that administers this survey which does not allow for comparability to other state programs.

SURVEY METHODOLOGY

MRMIB conducted the survey through an independent survey vendor, DataStat, Inc., using the instrument developed by the CAHPS® consortium[1] and modified for the Healthy Families Program. The instrument was based on the Child Medicaid version of the Consumer Assessment of Health Plan Survey (CAHPS®) 2.0H which contains 70 questions pertaining to nine aspects of care: access to dental care, customer service, communication of providers, and quality and satisfaction of dental plan services and dental care received. Responses to the questions have been summarized into four global ratings and five composite scores. The global ratings included ratings of dental plan, dental care, regular dentist and dental specialist. The composite scores addressed getting needed dental care, getting dental care quickly, how well dentists communicate, helpfulness and courteousness of dental office staff and customer service.

Datastat, Inc. conducted the survey over an eight week period using a single mode (mail-only) 5 step protocol between the months of September and December. This consisted of a pre-notification mailing, an initial survey mailing and a reminder postcard to all respondents, and a second survey mailing and second reminder postcard to non-respondents. The pre-notification and follow-up correspondences were developed based on recommended samples from the CAHPS® 2.0H protocol. Because the D-CAHPS® survey is still under development, the protocol for the telephone follow-up is not available for this survey.

[1]The CAHPS® consortium was established by the Agency for Health Care Policy and Research (now known as Agency for Health Care Research and Quality). The consortium consists of the RAND Corporation, Harvard Medical School and the Research Triangle Institute.

The survey was conducted in five languages – English, Spanish, Cantonese, Korean and Vietnamese. Families selected for the survey received the survey in English, and Spanish, Cantonese, Korean or Vietnamese if one of these languages was designated as the primary language on the families' HFP application.

DataStat, Inc. selected a random sample of families using a modified version of the NCQA (National Committee for Quality Assurance) protocols for conducting the CAHPS® 2.0H survey. Families with children between the ages of 4 and 18 years as of June 30, 2003 who were continuously enrolled in their dental plan for at least 12 months were eligible to participate in the survey. Families with children under the age of 4 were not selected for the survey because of the likelihood that these children would not have seen a dentist.

Of the families who were eligible for the survey, only those families who did not receive a previous HFP consumer survey for health plans were selected. This was to ensure that no family was burdened with having to complete a health and dental survey in the same year. The number of families selected for the survey from each dental plan participating in the HFP was 900. A total of 4,500 surveys were distributed. The number of families who were selected for the survey and the distribution of language surveys for each participating dental plan is presented in Table 1.

Table 1 – Distribution of Surveys in Each Language Group by Dental Plan

Dental Plan	Total	E	S	C	K	V
Access Dental	900	357	483	25	22	13
Delta Dental	900	410	404	48	19	19
Health Net Dental	900	352	477	45	17	9
Premier Access	900	604	293	2	1	0
Universal Care Dental	900	331	529	17	8	15
Total	4,500	2,054	2,186	137	67	56

E= English S=Spanish C=Cantonese K=Korean V=Vietnamese

SURVEY RESULTS: OVERALL RATINGS

All plans met the minimum requirement to yield an adequate sample size to complete the survey and allow for the analysis of plan comparisons. The minimum number of responses needed for the analysis was 411 completed surveys which is the target number that NCQA defines for accreditation purposes. This goal allows for at least 100 responses per question to yield a comparative analysis and is comparable to most types of statistical testing.

The following pages contain the HFP program and individual plan survey overall ratings and composite results from the 2003 D-CAHPS® 1.0 survey. The responses to the survey were summarized into four rating and five composite questions. Responses that indicate a positive experience were considered achievement scores as identified below.

Rating Question Responses: For the four rating questions, a 10-point scale was used to assess overall experience with dental plans, providers, specialists and dental care. For this scale, "0" represents the worst and "10" represents the best. The achievement scores for these questions were determined by the percentage of families responding to each question using an 8, 9, or 10 rating. Individual plan scores for the 2003 survey are compared with the overall program score in 2003 and 2002 and a *benchmark*. This benchmark is based on the highest score achieved by a participating dental plan with a minimum of 75 responses.

Between 65 and 71 percent of families gave high ratings for *Dental Care*, *Dental Plan*, *Personal Dentist* and *Dental Specialist*. The rating for *Dental Specialist* had the highest achievement score for 2003 (71 percent). The rating of *Dental Specialist* also had the highest achievement score for 2002 (75 percent). Although the 2003 score (71 percent) was lower than the 2002 score (75 percent), the differences in scores were not statistically significant.

The rating of *Dental Plan* had the lowest achievement score for 2003 (65 percent). The rating of *Dental Plan* also had the lowest achievement score for 2002 (65 percent). This rating also had the widest range of scores among plans from 58 to 81 percent.

Of the ratings achieved by individual plans, the highest score was achieved by Delta Dental for overall rating of *Dental Plan* (81 percent). The lowest score obtained was by Universal Care for the overall rating of *Dental Plan* (58 percent).

For each rating question, some plans had scores that were consistently higher or lower than the HFP overall score. Access

Dental and Universal Care Dental had 2 to 3 scores that were statistically significantly below the program average. Premier Access and Delta Dental had at least 2 scores that were statistically significantly above the program average. These results are shown in Table 2.

Table 2 – Statistically Significantly Higher and Lower than HFP Overall Ratings Scores

Dental Plan	Overall Dental Plan	Overall Dental Care	Overall Personal Dentist	Overall Dental Specialist
Access Dental	▼	▼		
Delta Dental		▲	▲	
Health Net Dental		▼	▼	
Premier Access		▲	▲	
Universal Care Dental	▼	▼	▼	

▲= Statistically significantly higher than HFP Overall Rating Scores
▼= Statistically significantly lower than HFP Overall Rating Scores

Table 3 shows changes in plan scores that have increased or decreased 4 or more percentage points from 2002 to 2003. Health Net Dental showed improvement in 2 areas. Access Dental had scores decline in 1 area and Premier Access had scores decline in 3 areas.

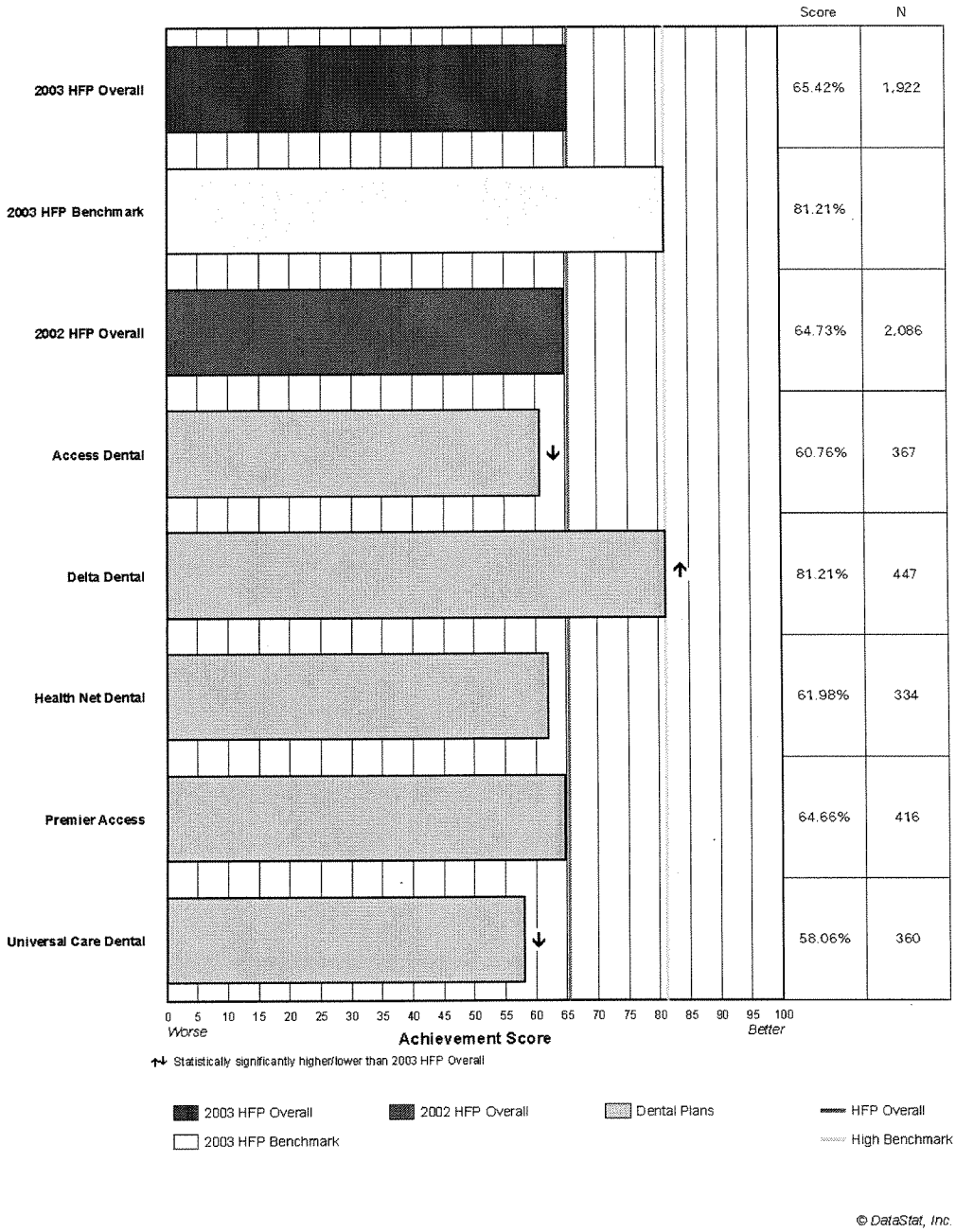
Table 3 – Plan Performance Changes in Overall Ratings 2002-2003

Dental Plan	Overall Dental Plan	Overall Dental Care	Overall Personal Dentist	Overall Dental Specialist
Access Dental				↓ (4%)
Delta Dental				
Health Net Dental		↑ (6%)	↑ (5%)	
Premier Access		↓ (5%)	↓ (6%)	↓ (10%)
Universal Care Dental				

Pages 6-9 present the individual scores for each plan for each rating.

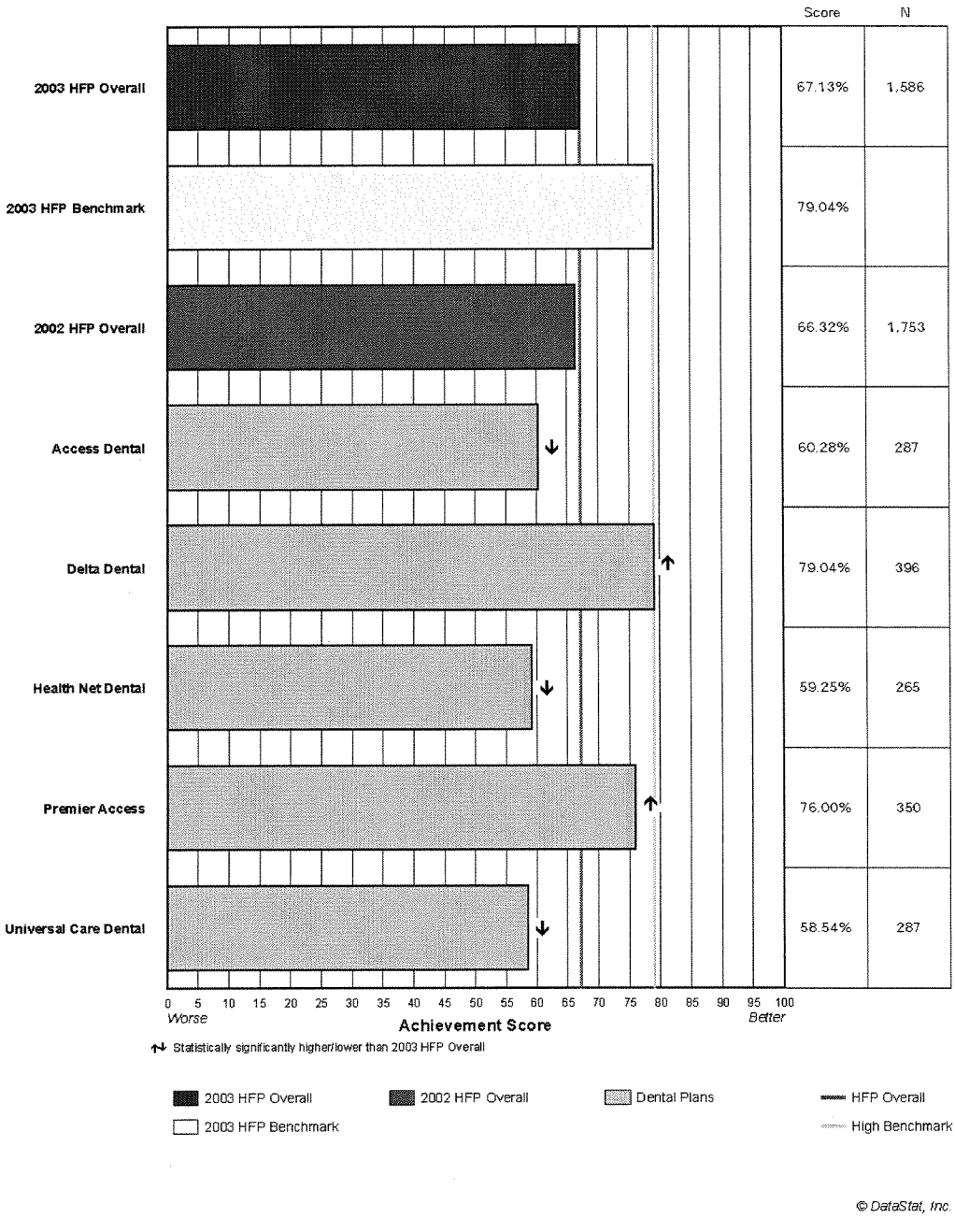
Overall Ratings

Q52. Overall rating of dental plan



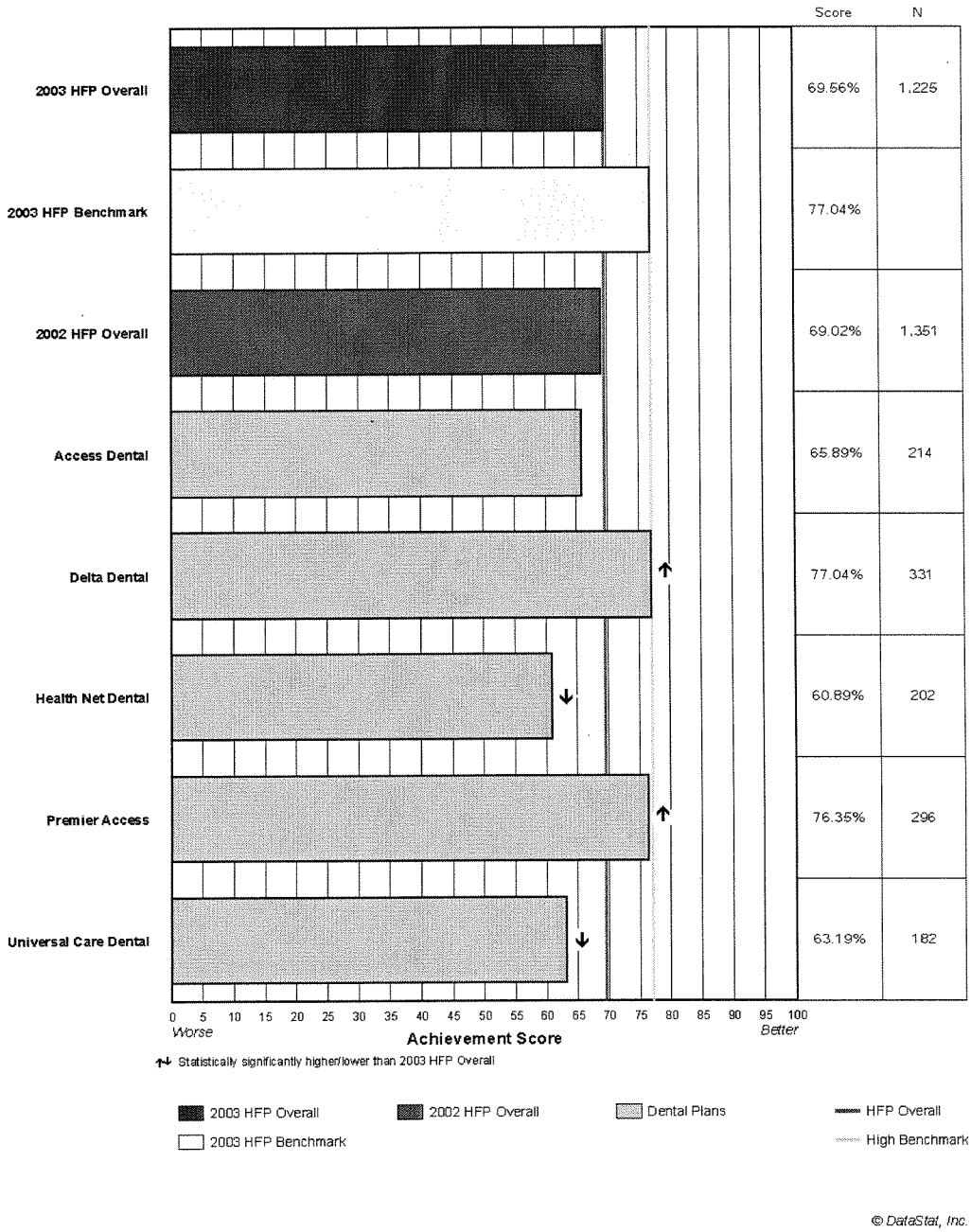
Overall Ratings

Q40. Overall rating of dental care



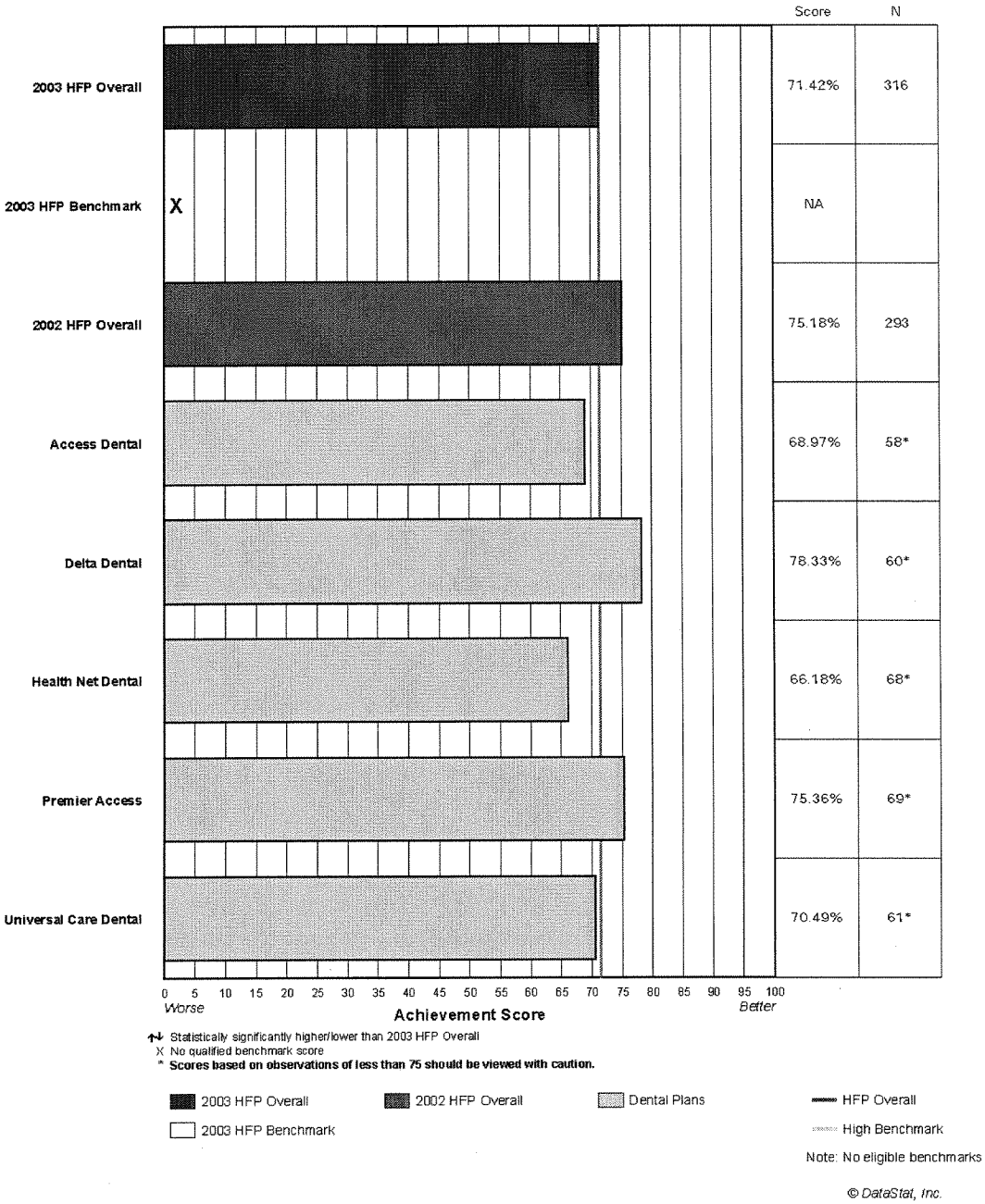
Overall Ratings

Q9. Overall rating of personal dentist



Overall Ratings

Q14. Overall rating of dental specialist



SURVEY RESULTS: COMPOSITE SCORES

Composite Score Results: For the composite score, questions that are related to the same broad domain of performance are grouped. For example, *Getting Dental Care Quickly* includes questions about getting advice by phone, how soon appointments were scheduled and the time spent waiting in the dentist's office. The achievement score for each composite is determined by the percentage of families who respond positively to each question that comprises the composite. A response in considered positive if the answers are "not a problem" for the questions comprising the *Getting Needed Dental Care* and *Customer Service* composites, and "usually" and always" for the *Getting Care Quickly*, *How Well Doctors Communicate* and *Courteous and Helpful Office Staff* composites.

The survey questions that comprise each composite score are listed below.

Getting Needed Dental Care

- Able to get your child a dental office or clinic you are happy with
- Able to get a referral to a specialist for child
- Able to get the care for child believed necessary
- No problems with delays in child's dental care while awaiting approval

Getting Dental Care Quickly

- Usually or always got help of advice needed for child
- Child usually or always got an appointment to fill or treat a cavity as soon as wanted
- Child usually or always got an appointment for routine care as soon as wanted
- Child usually or always got needed care for mouth pain or dental problem as soon as wanted
- Child never or sometimes waited more than 15 minutes in dentist's office or clinic

How Well Dentists Communicate

- Dentists usually or always listened carefully
- Never or sometimes had a hard time speaking with or understanding the dentist because you spoke different
- Dentists usually or always explained things in an understandable way
- Usually or always got an interpreter when needed
- Child usually or always got an interpreter when needed

- Child never or sometimes had a hard time speaking with or understanding dentist because he or she spoke different languages
- Dentists usually or always explained things to child in an understandable way
- Dentists usually or always spent enough time with child

Courteous and Helpful Office Staff
- Usually or always treated with courtesy and respect by office staff
- Office staff usually or always helpful

Customer Service
- Able to find or understand information in written materials
- Able to get help needed when you called child's dental plan's customer service

The results of the survey indicated that at least 82 percent of families responded positively to two of the composite questions. The composite ratings of *How Well Dentists Communicate* and *Courteous and Helpful Office Staff* had the highest number of positive responses (82 percent). The composite ratings of *How Well Dentists Communicate* and *Courteous and Helpful Office Staff* also had the highest number of positive responses for 2002 (81 percent). The increase in the composite rating of *How Well Dentists Communicate* from 2002 to 2003 is statistically significant.

The three composite ratings that had less than 82 percent of families responding positively were *Getting Needed Dental Care*, *Getting Dental Care Quickly* and *Customer Service*. The composite rating of *Customer Service* had the lowest percentage of positive responses for 2003 (56 percent). The composite rating of *Customer Service* also had the lowest percentage of positive responses for 2002 (53 percent). The difference in the composite rating of *Customer Service* from 2002 to 2003 is not statistically significant.

With respect to individual dental plan scores, Premier Access achieved the highest composite score among all dental plans. Ninety-one percent of Premier Access' subscribers responded positively to *How Well Dentists Communicate and Courteous and Helpful Office Staff*. Universal Care achieved the lowest composite score among all plans. Forty-nine percent of their subscribers responded positively to the *Getting Dental Care Quickly* composite.

For each composite question, some plans had scores that were consistently higher or lower than the HFP overall score. Access Dental and Universal Care Dental had at least 3 scores that were

statistically significantly below the program average. Premier Access and Delta Dental had at least 3 scores that were statistically significantly above the program average. These results are shown in Table 4.

Table 4 – Statistically Significantly Higher and Lower than HFP Overall Composite Scores

Dental Plan	Getting Needed Dental Care	Getting Dental Care Quickly	How Well Dentists Commun-icate	Courteous & Helpful Office Staff	Customer Service
Access Dental		▼	▼	▼	
Delta Dental	▲	▲	▲	▲	
Health Net Dental			▼		
Premier Access Dental		▲	▲	▲	
Universal Care Dental	▼	▼	▼	▼	

▲ = Statistically significantly higher than HFP Overall Rating Scores
▼ = Statistically significantly lower than HFP Overall Rating Scores

With respect to changes in plans scores, 1 plan (Health Net Dental) showed improvement in 4 areas. Premier Access Dental and Universal Care Dental showed improvement in 1 area. Table 5 details the changes in plan scores from 2002 to 2003. Only those changes that were 4 percentage points or more are shown.

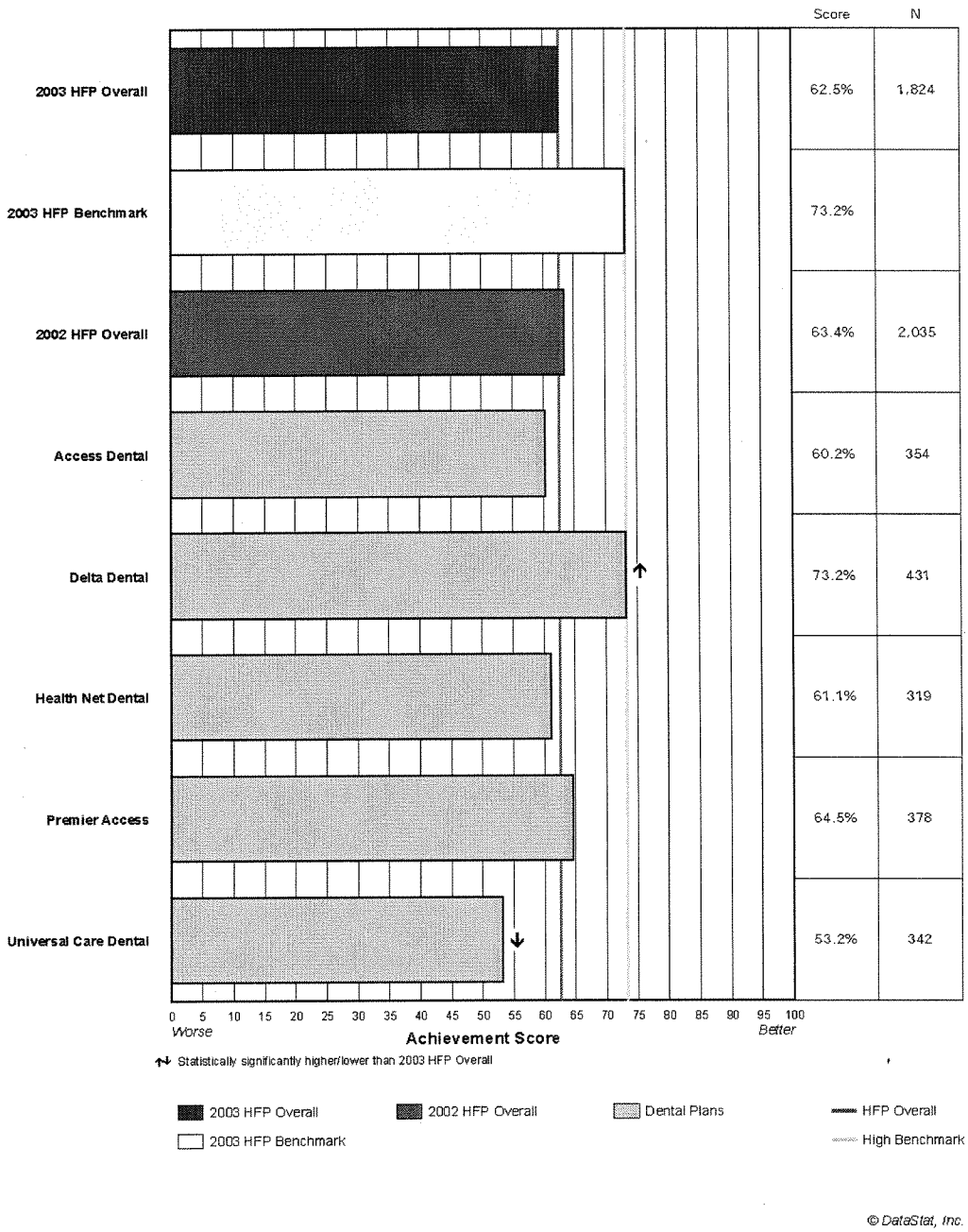
Table 5 – Plan Performance Changes in Overall Composite Scores 2002-2003

Dental Plan	Getting Needed Dental Care	Getting Dental Care Quickly	How Well Dentists Commun-icate	Courteous & Helpful Office Staff	Customer Service
Access Dental					
Delta Dental					
Health Net Dental		↑ (6%)	↑ (5%)	↑ (7%)	↑ (13%)
Premier Access Dental					↑ (5%)
Universal Care Dental				↑ (5%)	

The individual plan scores for all composites are shown on pages 13-18.

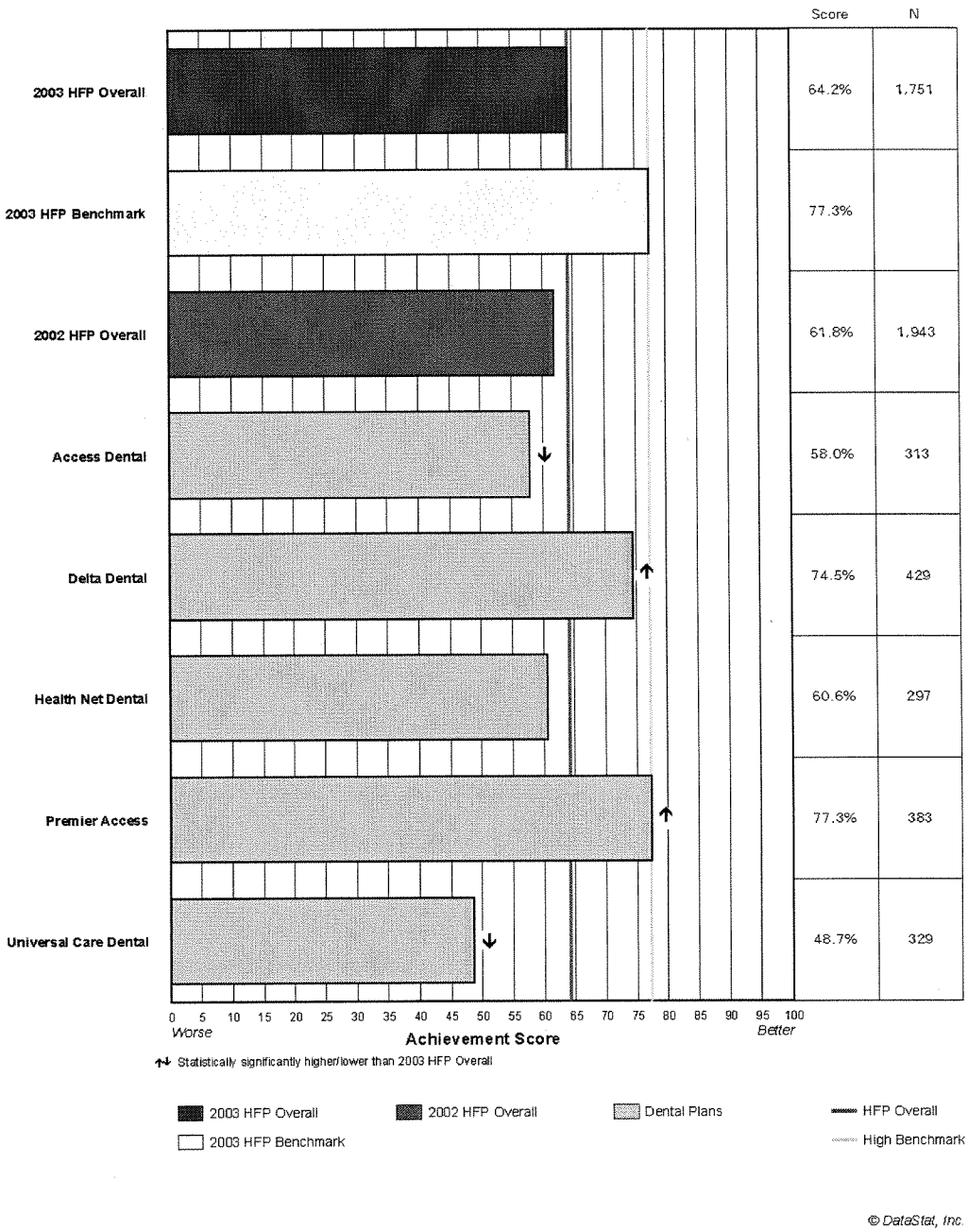
Getting Needed Dental Care

Composite Score



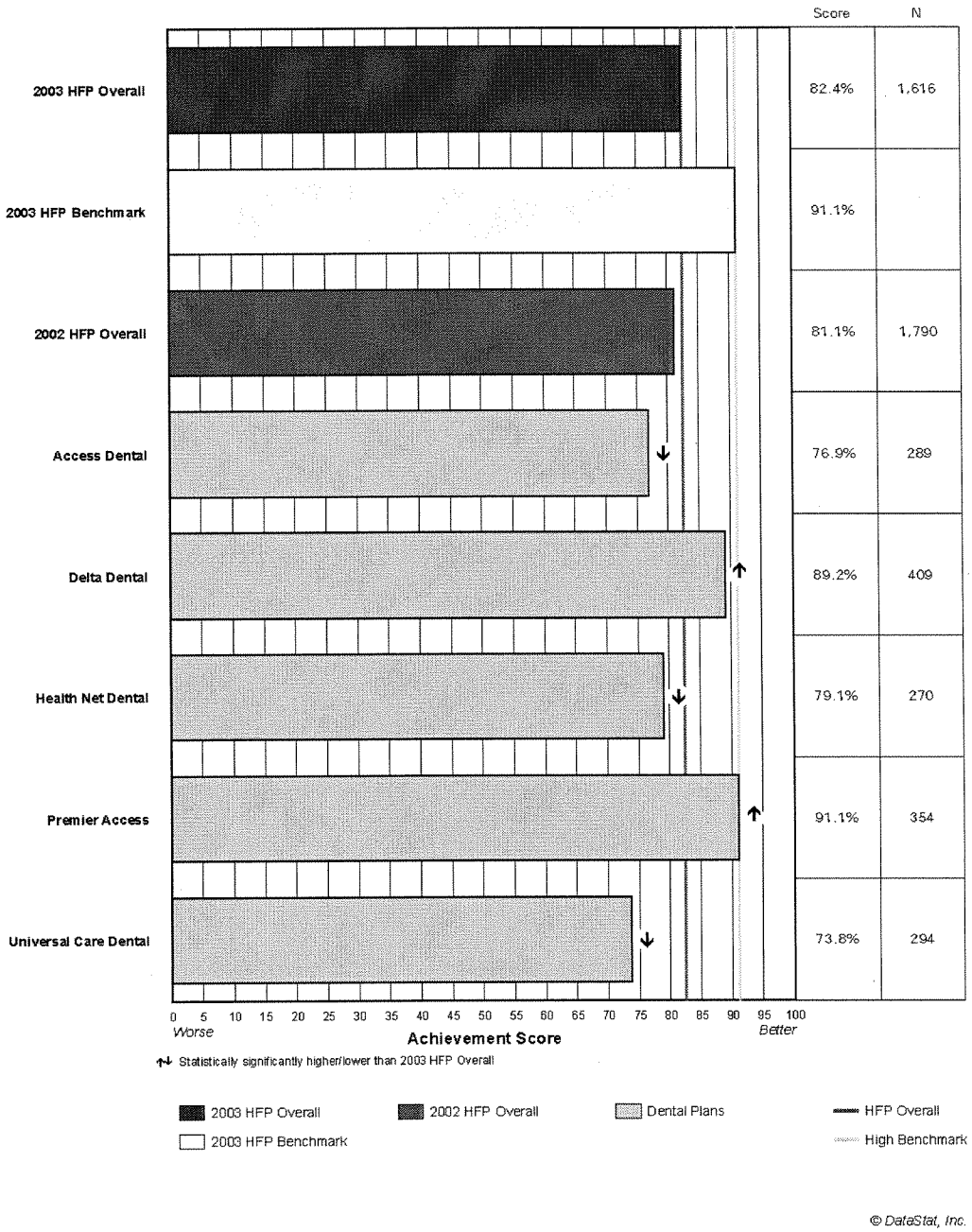
Getting Dental Care Quickly

Composite Score



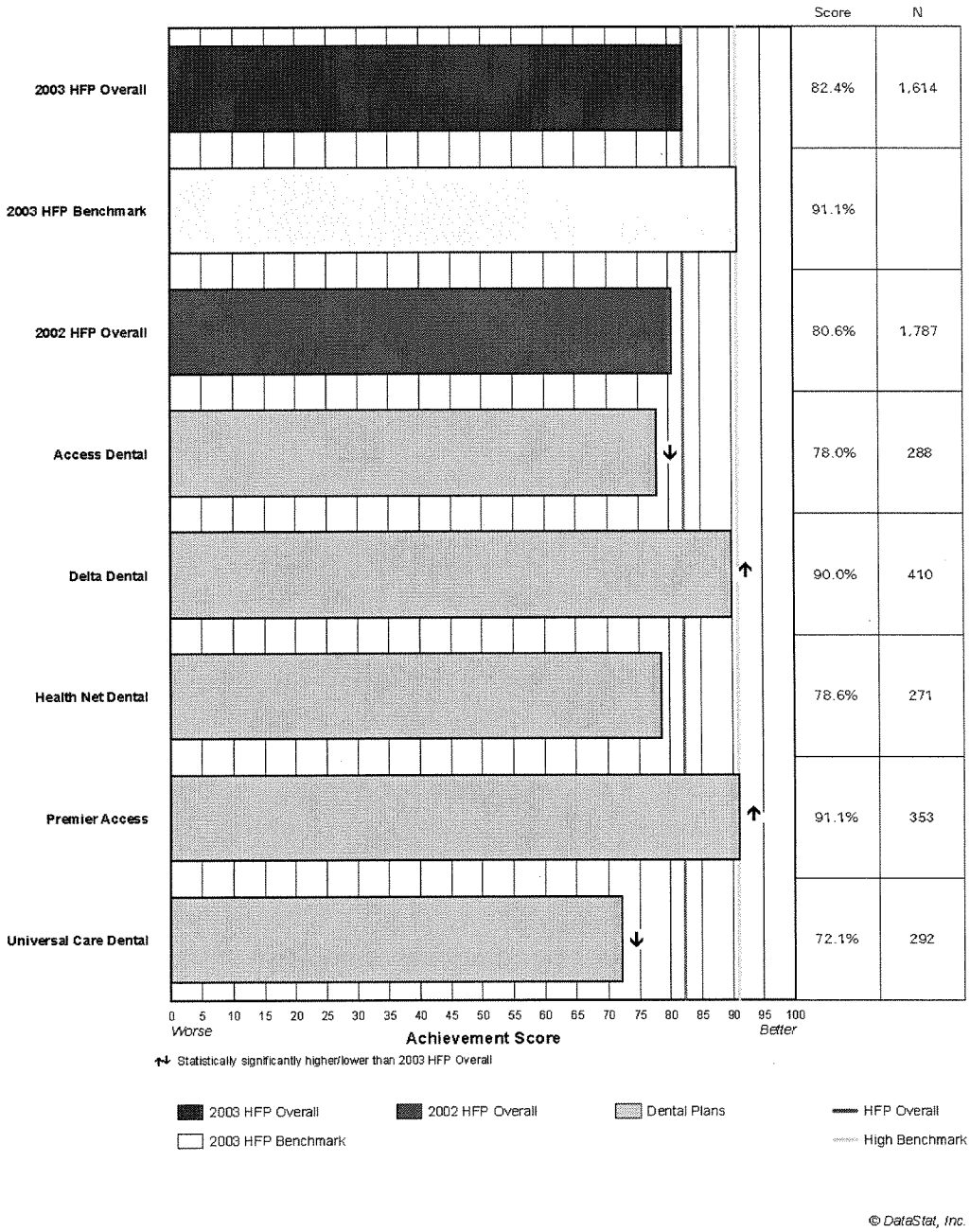
How Well Dentists Communicate

Composite Score



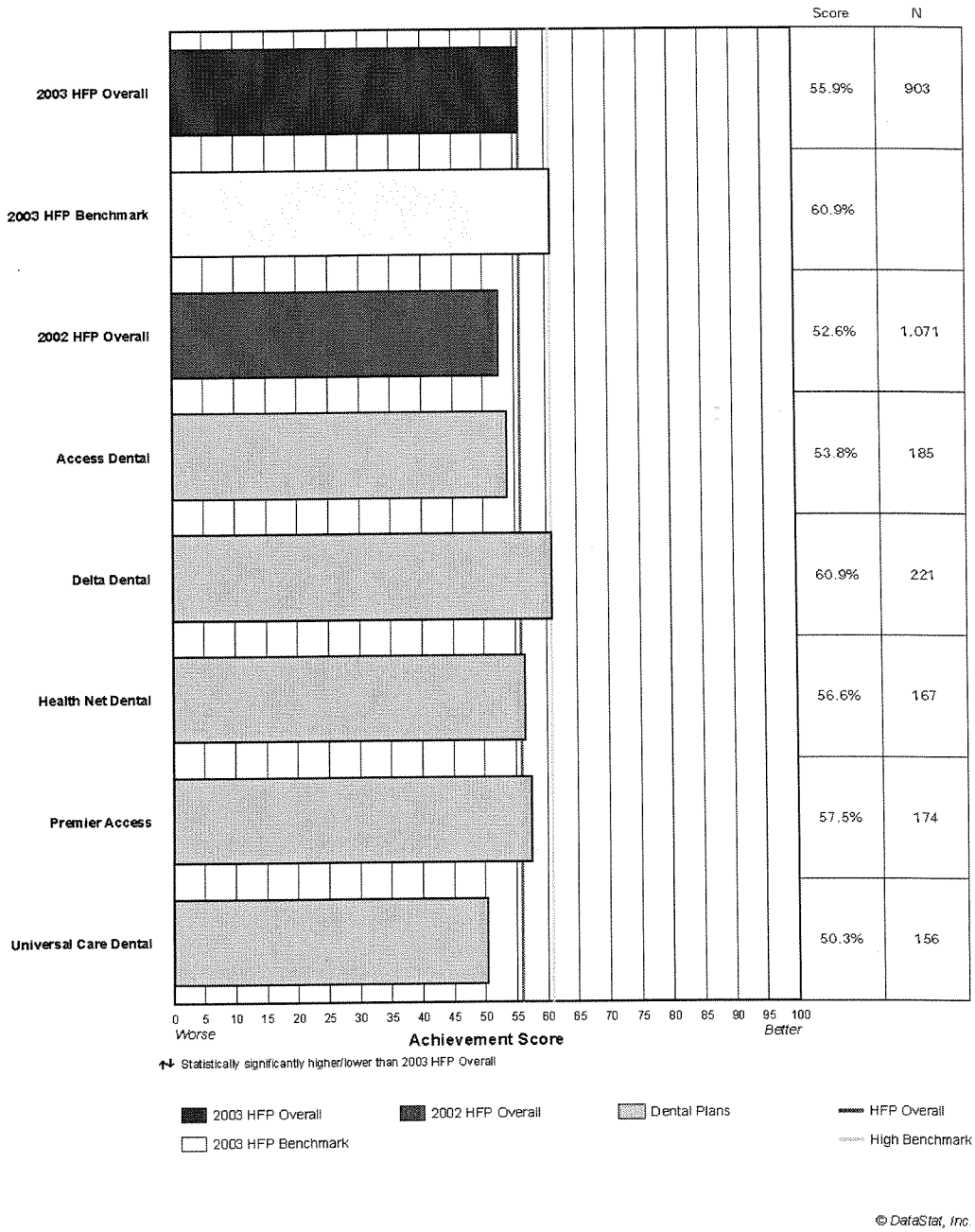
Courteous and Helpful Office Staff

Composite Score



Customer Service

Composite Score



SURVEY RESULTS: CORRELATION OF SCORES AND SATISFACTION

In addition to the overall and individual plan scores, DataStat, Inc. conducted three additional analyses to illustrate the program's strongest and weakest areas of performance and the top ten questions that were highly correlated with satisfaction. The areas of strongest and weakest performance are based on the highest and lowest achievement score for a particular question. There were five items that had more than 83 percent of subscribers responding positively. There were 6 items that had less than 80 percent of subscribers responding positively with one item as low as 60 percent. In the areas of weakest performance, all items were highly correlated with satisfaction. Tables 6 and 7 outline the areas of strongest and weakest performance.

A correlation co-efficient of .40 or greater indicates a relatively high correlation with plan satisfaction. Coefficients less than 0.40 indicate a low correlation with plan satisfaction. All areas shown in Table 7 have a high correlation with plan satisfaction.

Table 6 – Areas of Strongest Performance

Question	HFP Achieve-ment Score	Correlation with overall Satisfaction (Yes or No)	Composite Group
Child never or sometimes had a hard time speaking with or understanding dentist because he or she spoke different languages	95.7%	N (0.05)	How Well Dentists Communicate
Never or sometimes had a hard time speaking with or understanding dentist because you spoke different languages	89.4%	N (0.07)	How Well Dentists Communicate
Dentists usually or always showed respect	87.2%	N (0.35)	How Well Dentists Communicate
Usually or always treated with courtesy and respect by office staff	86.3%	N (0.33)	Courteous & Helpful Office Staff
Dentists usually or always explained things to child in an understandable way	83.0%	N (0.29)	How Well Dentists Communicate

Table 7 – Areas of Weakest Performance

Question	HFP Achieve-ment Score	Correlation with overall Satisfaction (Yes or No)	Composite Group
Child usually or always got needed care for mouth pain or dental problem as soon as wanted	60.8%	Y (0.46)	Getting Dental Care Quickly
Overall rating of dental care	67.1%	Y (0.57)	Overall Ratings
Usually or always got help or advice needed for child	68.3%	Y (0.43)	Getting Dental Care Quickly
Overall rating of personal dentist	69.6%	Y (0.49)	Overall Ratings
Office Staff usually or always helpful	78.4%	Y (0.43)	Courteous & Helpful Office Staff
Dentists usually or always listened carefully	78.6%	Y (0.42)	How Well Dentists Communicate

There were a few other areas that were moderately correlated with satisfaction. These are shown in Table 8.

Table 8 - Other Items Correlated with Satisfaction

Question	HFP Achieve-Ment Score	Correlation with Satisfaction (Yes or No)	Composite Group
Overall rating of dental specialist	71.4%	Y (0.45)	Overall Ratings
Dentists usually or always spend enough time with child	76.3%	Y (0.40)	How Well Dentists Communicate
No problems with delays in child's dental care while awaiting approval	73.0%	N (0.37)	Getting Needed Dental Care

(Note: A correlation coefficient of 0.40 or greater indicates a relatively high correlation with plan satisfaction. Coefficients less than 0.40 indicate a low correlation with plan satisfaction.)

CONCLUSIONS

The information presented in this report represents a ground-breaking effort to understand the experience families have with dental plans. Because the D-CAHPS® survey instrument is new, comparative data is not yet available.

The results of the survey show significant variations in the scores between the dental plan types. Most plans showed improvement in at least one area from 2002 results to 2003. As seen in last year's report, the open access exclusive provider organization (EPO) dental plans had higher scores than the dental maintenance organization (DMO) plans. Further study is required to understand the dramatic differences in these results.

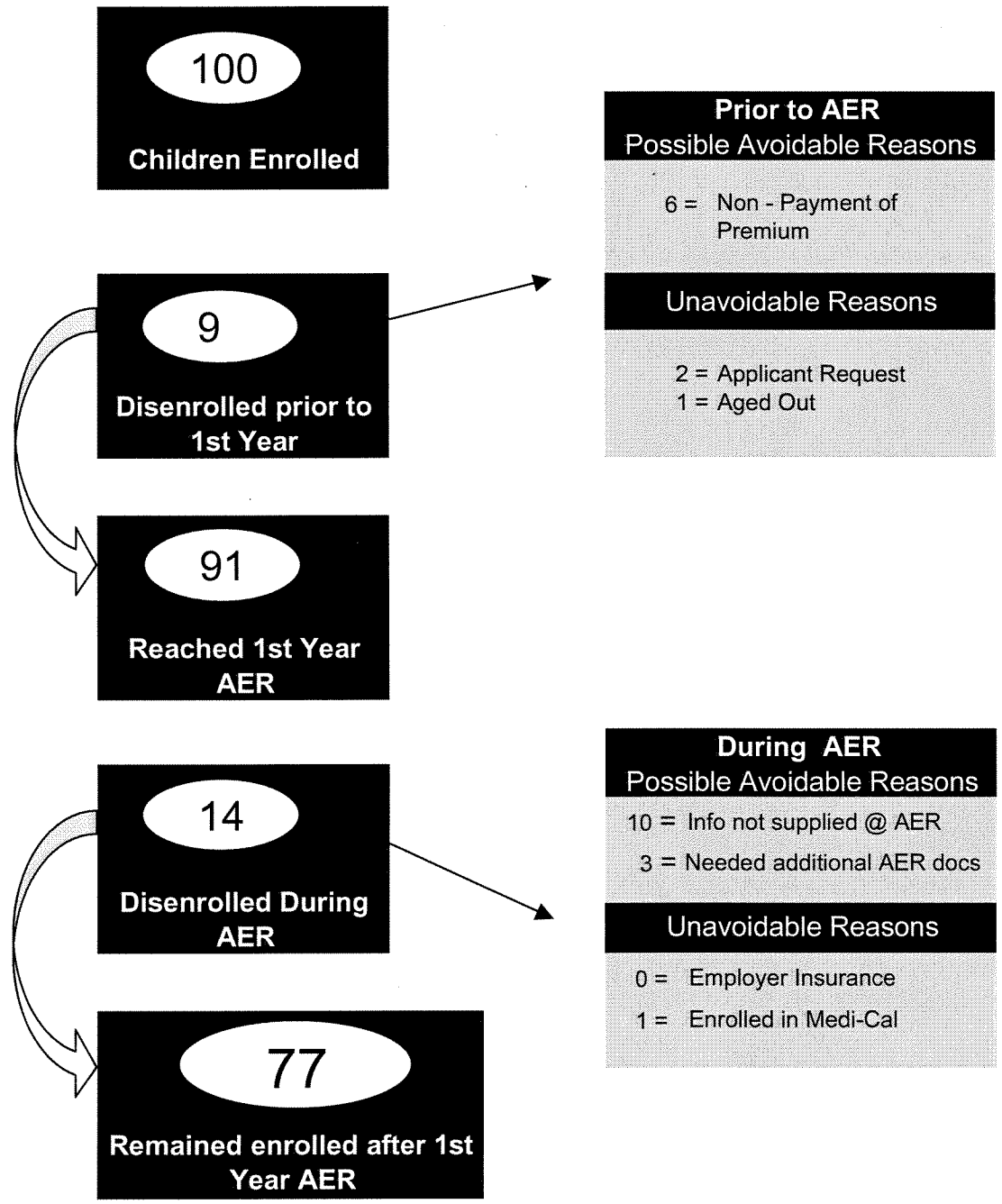
Acknowledgements
Prepared by Cristal Milberger, Benefits Specialist

Assisted by Lorraine U. Brown, Deputy Director, Benefits and Quality Monitoring

Attachment V:

2004 Annual Retention Report

Retention and Disenrollment
Enrolled January 2004 to December 2004
N = 171,206



Retention and Disenrollment
Enrolled January 2004 to December 2004
N = 171,206

Breakdown of Families Disenrolling after 1 Year

% of Families Disenrolled after 1 Year — 22%

Because of .....

Unavoidable Reasons — 3%

Employer Insurance	0%
Enrolled in Medi-Cal	1%
Aged Out	1%
Applicant's Request	2%

And .....

Possibly Avoidable Reasons — 19%

Info not supplied @ AER	10%
Needed additional AER Docs	3%
Non Payment of Premiums	6%

Of the Possibly Avoidable Reasons .....

NASHP Retention Study of 2001
indicated that **60%** of families determined that they were ineligible and failed to inform S-CHIP programs of new coverage or status of change.

19% X .6 = 11%

Which leaves those not accounted for .....

Possibly Avoidable Reasons 19%
Explained by NASHP Study 11%

8%

Attachment VI:

Healthy Families Program Health Status Assessment (PedsQL™) 2004

The Healthy Families Program
Health Status Assessment (PedsQL™) Final Report

Revised September 2004

Managed Risk Medical Insurance Board

EXECUTIVE SUMMARY

The most significant achievement of the Healthy Families Program (HFP), California's State Children's Health Insurance Program (SCHIP), has been to increase access to medical services for children enrolled in the program. While it is reasonable to presume that improved access to care would affect the health status of children in a positive manner, only through a special project has MRMIB been able to document the connection between access to care and positive changes in health status. MRMIB implemented a longitudinal survey of families of children who were newly enrolled in the HFP in 2001 to measure changes in access to care and health status among these children over two years of enrollment.

Results from this project showed:

- Dramatic, sustained improvements in health status for the children in the poorest health and significant, sustained increases for these children is paying attention in class and keeping up in school activities.
- Meaningful improvement in health status for the population at large.
- Increased access to care and reduced foregone health care for children in the poorest health and the population at large.
- A lack of significant variation by race and language in reports of no foregone care--the most significant variable associated with access.

The most significant improvements occurred after one year of enrollment in the program. These gains were sustained through the second year of enrollment. Because the survey does not quantify all factors that are attributable to changes in health status, it is not known how much of an impact changes in access to care has on the overall changes seen in health status. It is also not known what the underlying health status is of the children participating in this survey. Therefore, the strongest conclusion and/or correlation that can be made regarding these results is that the HFP contributes to the improvements in health status by increasing access to health care services.

This report describes the project in detail and presents specific findings from the project.

BACKGROUND

MRMIB conducted this project to fulfill a legislative mandate to report changes in health status among children enrolled in the Healthy Families

Program.[1] To measure changes in health status, MRMIB followed newly enrolled children over a two-year period. At the recommendation of the HFP Quality Improvement Work Group, MRMIB selected the Pediatric Quality of Life Inventory™ or PedsQL™ as the instrument to use to assess the health status of the children. The PedsQL™ is a short questionnaire, consisting of 23 questions that address physical and psychosocial aspects of health. The questionnaire was selected because of its brevity, ease in completion, and use in broad age groups (ages 2 through 18). The developers of the PedsQL™ questionnaire have also used the questionnaire in Medicaid and commercial populations in California. Research has shown that self-assessment is an acceptable method for measuring health status among populations.[2,3,4] Prior research on the PedsQL™ has demonstrated a consistent difference in health status scores between healthy children and children with chronic health conditions such as asthma, arthritis, cancer and diabetes. Healthy children have been shown to have significantly higher scores than children with clinically diagnosed chronic conditions[5].

The Survey Process

The survey was conducted by mailing the PedsQL™ to the families of approximately 20,000 HFP children who were newly enrolled in the program during the months of February and March 2001. Questionnaires were mailed to families during their first month of enrollment. Families received the survey in either English, Spanish, Vietnamese, Korean, or Chinese based on the primary language indicated on each family's HFP application. Each family received prior notification of the questionnaire during a welcome call they received from the HFP administrative vendor. In addition to the pre-notification call and the initial questionnaire, reminder post cards and a second questionnaire were mailed to non-responders. If the questionnaire was not returned after the second mailing, a follow-up call was made. Families who remained on the program as of February and March 2002 (6,881) and February and March 2003 (4,952) were sent a second and third survey. For each family, one child in the household was selected as the subject for the survey; a parent and the subject (if 5 years or older) were each given a questionnaire to complete.

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[1] California Insurance Code, Section 12693.92

[2]McHorney CA, Ware JE, Raczek AE. The MOS 36-item short-form health survey (SF-36): II. Psychometric and clinical tests of validity in measuring physical and mental health constructs. Medical Care 1993;31(3):247-263.

[3] McHorney CA, Ware JE, Jr., Lu JF, Sherbourne CD. The MOS 36-item Short-Form Health Survey (SF-36): III. Tests of data quality, scaling assumptions, and reliability across diverse patient groups. Medical Care 1994;32(1):40-66.

[4] Eisen M, Donald CA, Ware JE, Brook RH. Conceptualization and measurement of health for children in the health insurance study. Santa Monica, CA: RAND; 1980.

[5] Varni, J.W., Seid, M., Kurtin, P.S.; Peds QL™ 4.0: Reliability and validity of the Pediatric Quality of Life Inventory Version 4.0--Generic Core Scales in healthy and patient populations. Medical Care 39(8) 800-812.

The PedsQL™ Questionnaire

The PedsQL™ Questionnaire contains 23 core questions that address the physical and psychosocial aspects of health. With respect to the psychosocial aspect of health, the questionnaire examines social, emotional, and school functioning. For each aspect of health, survey participants are asked to rate how much of a problem five to eight "items" have been in the past 30 days.

The questionnaire varies slightly among four age groups to ensure that items asked are developmentally appropriate. The questionnaire is administered to young children (ages 5 to 7), children (ages 8 to 12) and adolescents (ages 13 to 18). The questionnaire is also administered to parents of children ages 2 to 4 years (toddlers), young children (ages 5 to 7), children (ages 8 to 12) and adolescents (ages 13 to 18).

The questionnaire asks survey participants to respond using a 5-point scale indicating how much of a problem each item has been during the past month. The scale is designed so that 0 is never a problem, 1 is almost never a problem; 2 is sometimes a problem; 3 is often a problem and 4 is almost always a problem. For very young children (ages 5 to 7 years) the numerical scale is replaced with a scale of smiley faces. Parents are asked to assist their very young children (ages 5 to 7) in completing the questionnaire by having the child assign a smiley face. A copy if the questionnaire is included in Exhibit A.

The PedsQL™ Questionnaire was supplemented for use in the Healthy Families Program by including 13 additional questions regarding access to care and chronic illness. Access related items included: the presence of a personal physician, foregone health care, and problems getting care. These additional questions were included to assess changes in access to care.

The additional survey items were adapted from the PedsQL™ Family Information Form[6], the Consumer Assessment of Health Plans Study (CAHPS™)[7] (a measure of health plan performance from the consumer's perspective), and a study examining foregone care among adolescents[8].

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[6] Varni JW, Seid M, Kurtin PS. PedsQL 4.0: Reliability and Validity of the Pediatric Quality of Life Inventory Version 4.0 Generic Core Scales in Healthy and Patient Populations. *Medical Care.* 2001;39(8):800-812.

[7] Hays RD, Shaul JA, Williams VS, et al. Psychometric properties of the CAHPS 1.0 survey measures. Consumer Assessment of Health Plans Study. *Medical Care.* 1999;37(3 Suppl):MS22-31.

[8] Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. *JAMA* 1999;282(23):2227-34.

Calculation of Health Status Scores

Each response received from survey participants is reverse scored and linearly transformed to a 100 point scale where 0 becomes 100 points, 1 becomes 75 points, 2 becomes 50 points, 3 becomes 25 points and 4 becomes 0 points. The higher the score, the better the health related quality of life. Three summary scores are calculated for each completed questionnaire. The Total Score (all 23 items) is computed as the mean of the item responses divided by the number of items answered in the Physical and Psychosocial sub-scales. The Physical Score is the mean of the item responses for that aspect of health. The Psychosocial Health Score is calculated by summing the item responses for the Emotional, Social and School functions scales and dividing by the number of items answered. Based on previous studies using the PedsQL, children in good health have scores around 83. Children in poor health have scores in the mid-60s to low 70s.[9]

RESULTS

Response Rates

The results of the survey are based on a significant number of surveys that had been returned by parents over the 2 years of the project. Because each year approximately 30 percent of children do not re-enroll in the program for various reasons, the total sample for 2002 and 2003 declined from 2001. At the beginning of the project, approximately 20,000 surveys were mailed to newly enrolled HFP subscribers and their caregivers. By the end of the project, survey data was available on 3,738 children who had remained enrolled in the program from 2001 through 2003 and had completed the three surveys. The researchers view the response rates for each year as quite robust and of more than adequate size on which to base conclusions. Table 1 shows the disposition of the sample from 2001 through 2003.

Table 1: Disposition of Sample from 2001 through 2003

Year of Survey	Total Sample	Total Surveys Returned	Response Rates	Number of children leaving HFP at the end of the year
2001	20,000	10,241	51.2%	3,360
2002	6,881	6,005	87.3%	1,929
2003	4,952	3,738	75.5%	----------

Over the two year period, the response rates among age, ethnic and language groups remained constant. For all three surveys, the distribution

[9] Varni, J.W., Burwinkle, T.M., Katz, E.R., Meeske, K., & Dickinson, P. (2002). The PedsQL* in pediatric cancer: Reliability and validity of the Pediatric Quality of Life Inventory* Generic Core Scales, Multidimensional Fatigue Scale, and Cancer Module. *Cancer*. 94, 2090-2106.

of returned surveys among ethnic and language groups was consistent with the ethnicity and language distribution of the total HFP population.

However, response rates within ethnic and language groups differed. Among the three surveys, Latino parents were more likely to complete the survey; African American parents were less likely to complete the survey.

With respect to the five language groups, English respondents were less likely to complete the survey, while Spanish respondents were more likely in 2001 and 2002 to complete the survey. For 2003, results revealed that Korean and Vietnamese respondents were more likely to complete the survey.

Among the age groups, parents of toddlers were more likely to return the surveys in 2001. For the 2002 and 2003 surveys, the response rates across age groups were very similar. Table 2 shows the response rates by age, language and ethnicity.

Table 2: Response rates by age, language, and ethnicity

	Baseline (2001)		**Year 1 (2002)**		**Year 2 (2003)**	
	Response Rate	Percent of Sample	Response Rate	Percent of Sample	Response Rate	Percent of Sample
AGE						
Toddler (2-4)	59%	30.5%	89%	19.5%	74%	11.1%
Young Child (5-7)	48%	24.3%	87%	26.0%	75%	24.4%
Child (8-12)	50%	31.4%	87%	35.2%	77%	39.6%
Adolescent (13-18)*	47%	13.8%	87%	19.6%	75%	24.9%
LANGUAGE†						
English	44%	43.0%	83%	38.6%	69%	36.1%
Spanish	58%	50.7%	91%	53.9%	79%	55.5%
Chinese	58%	3.3%	84%	1.43%	78%	1.5%
Korean	55%	1.7%	85%	2.31%	84%	1.9%
Vietnamese	56%	1.4%	85%	3.98%	82%	5.0%
ETHNICITY						
White	46%	13.7%	82%	12.6%	68%	11.2%
Latino	53%	61.5%	89%	62.2%	76%	62.3%
African America	37%	2.3%	79%	1.92%	66%	1.8%
Asian/Pacific Islander	54%	11.8%	82%	13.4%	79%	14.0%
Native American	46%	0.4%	89%	0.4%	83%	0.51%
Not Reported	50%	10.3%	85%	9.84%	77%	10.3%

* Because the project followed children for 2 years, and because children are no longer eligible for the program at age 19, the Baseline survey was only distributed to families with newly enrolled children who were ages 2 through 16.

† Language refers to language of the questionnaire

Health Status Scores at Baseline

The Baseline survey showed the mean parent proxy score for the HFP population surveyed was 81.38. Scores for the sub-scales ranged from

76.91 to 82.15. Given that prior research on the PedsQL™ shows that healthy children, on average, have a score of 83, the HFP results suggest that children newly enrolled in the HFP are generally healthy. Table 3 displays the Baseline scores calculated from parent responses.

Table 3: Baseline PedsQL™ Scores from Parent Reports

Scale	Score	Standard. Deviation.
Total	81.38	15.90
Physical	83.26	19.98
Psychosocial	80.25	15.82
Emotional Functioning	80.28	16.99
Social Functioning	82.15	20.08
School Functioning	76.91	20.16

A review of baseline scores by age, language and ethnicity reveals minor differences in scores in most cases. The widest range of scores appeared among age and language groups. Among the age groups, toddlers had the highest score. Among language groups, Vietnamese respondents had the highest score and Spanish respondents had the lowest scores. The scores among ethnic groups were less varied. Table 4 displays the scores among age, language and ethnic groups.

Table 4: Baseline PedsQL™ Scores from Parent Reports by Age, Language and Ethnicity

	Baseline Score	Standard Deviation
Age		
Toddler (2-4)	87.47	12.44
Young Child (5-9)	78.05	16.44
Child (8-12)	78.88	16.60
Adolescent (13-16)	79.48	16.38
Language		
Spanish	79.23	17.12
English	83.49	14.18
Chinese	83.22	13.91
Korean	82.88	15.82
Vietnamese	87.35	15.57
Ethnicity		
White	84.53	13.40
Latino	80.44	16.45
African American	82.90	13.63
Asian/Pacific Islander	82.32	15.70
Native American	83.75	15.79
Not Reported	81.17	15.77

Health Status Scores at Year 1 and Year 2

Because the overall survey population was healthy at Baseline, and remained so at Year 1 and Year 2, researchers focused the analysis of changes in health status on children who were at risk. Researchers defined "at risk" as those children who, by parent report, had scores in the lowest 25 percent of all PedsQL scores. At Baseline this comprised 2,481

children. At Year 1, 1,459 of these children remained on the program and at Year 2, there were 925 such children left in the sample. The distribution of ethnic and language groups between children with scores in the lowest quartile and children with scores in the top three quartiles were similar, with some exceptions. There was a higher percentage of Latino children (as a percentage of the total baseline population) in the lowest quartile compared to the top three quartiles. White children were more likely to be in the top three quartiles than in the lowest quartile. English respondents were less likely to be in the lowest quartile, while non-English respondents were more likely to be in the lowest quartile. Table 5 displays the ethnic and language distribution of scores between the lowest and top three quartiles.

Table 5: Ethnic and language distribution of children in the lowest and top three quartiles at Baseline

	Lowest Quartile at Baseline (total = 1,459)	Top Three Quartiles at Baseline (total = 8,782)
Ethnicity		
White	8.1%	14.2%
Latino	66.8%	61.2%
African American	1.1%	2.2%
Asian/Pacific Islander	13.2%	12.2%
Native American	0.3%	0.4%
Not Reported	10.5%	9.7%
Language		
English	29.1%	42.7%
Spanish, Vietnamese, Korean, Chinese	70.9%	57.3%

Scores for children who were in the lowest quartile at Baseline (with scores at or below 71.74) and enrolled in the program for two years showed dramatic improvement from Baseline to Year 1. The largest increase in scores was seen in the physical and social scales. There was no significant change seen from Year 1 to Year 2 as shown in Table 6, suggesting that these improvements were sustained over time. As a point of reference, a 4.5 point difference in scores is associated with a clinical change in health status that is noticeable by a parent.

It is possible that some improvement in measured health status for the lowest rank quartile would have occurred over time regardless of children's participation in Healthy Families. However, the dramatic improvement in score, of more than 12 points, is material.

Table 6: Changes in PedsQL™ Scores from Baseline to Year 1 and Year 2 in Children with Baseline Scores in the Lowest Quartile

Scores	Baseline n= 862*	Year 1	Change from Baseline to Year 1	Year 2	Change from Year 1 to Year 2	Net Change
Total	58.26	71.27	13.01	70.70	-0.57	12.44
(Std. Dev.)	(9.33)	(16.73)	-----	(17.01)	-----	----
Physical	54.51	70.84	16.33	71.15	.31	16.64
(Std. Dev.)	(17.88)	(22.71)	-----	(22.92)	-----	----
Psychosocial	60.31	71.00	10.69	70.41	-0.59	10.10
(Std. Dev.)	10.48	16.53	-----	16.46	-----	----
Emotional	66.67	72.05	5.38	71.73	-0.32	5.06
(Std.Dev.)	18.28	18.75	----	18.62	----	----
Social	57.37	71.59	14.22	72.12	0.53	14.75
(Std.Dev.)	16.82	22.58	----	21.71	----	----
School	55.65	68.45	12.80	67.05	-1.40	11.40
(Std.Dev.)	15.33	20.62	----	20.30	----	----

*Number shown reflects the number of completed parent PedsQL™ reports received
Differences in scores from Baseline to Year 1 are statistically significant.

Changes in Health Status Scores for Adolescents (ages 13 and older at baseline) in the lowest quartile

For the Year 1 report, researchers conducted an analysis to look at changes in scores among adolescents from Baseline to Year 1. The results showed that adolescents had scores that were not significantly different from all age groups. Also of note is that the changes in scores from Baseline to Year 1 for the adolescents in the lowest quartile was a dramatic improvement from Baseline and similar to that seen for all ages. Again, some improvement in health status for the lowest ranked quartile could occur over time regardless of participation in HFP. However, 12 points is a dramatic, and material improvement.

Table 7: Changes in PedsQL Total Scale scores for adolescents from Baseline to Year 1 for adolescents based on parent report

Quartiles	Baseline	Year 1	Change
Lowest Quartile - Adolescents	58.2	70.6	12.4
Lowest Quartile - All Ages	58.0	71.7	13.7
All Quartiles- Adolescents	79.7	80.9	1.2
All Quartiles - All Ages	81.3	81.3	0.0

Differences in scores within the lowest quartile are significant.

There was no significant change seen from Year 1 to Year 2 , suggesting that these improvements sustained over time. The largest increase in scores was seen in the physical and social scales.

Table 8: Changes in PedsQL Total Scale scores for adolescents in the lowest quartile from Baseline to Year 1 and Year 2 for adolescents based on parent report

Scores	Baseline n=144	Year 1	Change from Baseline to Year 1	Year 2	Change from Year 1 to Year 2	Net Change
Total	59.06	70.90	**11.84**	69.92	-0.98	10.86
(Std. Dev.)	(9.65)	(16.28)	-----	(17.03)	-----	----
Physical	58.28	71.28	**13.00**	70.87	-0.41	12.59
(Std. Dev.)	(18.78)	(21.70)	-----	(23.32)	-----	----
Psychosocial	59.44	70.51	**11.07**	69.45	-1.06	10.01
(Std. Dev.)	(10.48)	(16.53)	-----	(16.46)	-----	----
Emotional	63.43	69.92	**6.49**	69.87	-0.05	6.44
(Std.Dev.)	(20.54)	(20.33)	----	(20.60)	----	----
Social	59.45	75.25	**15.80**	73.84	-1.41	14.39
(Std.Dev.)	(16.82)	(22.58)	----	(21.71)	----	----
School	55.29	66.10	**10.81**	65.13	-0.97	9.84
(Std.Dev.)	(16.31)	(21.22)	----	(20.30)	----	----

Differences in scores from Baseline to Year 1 are significant.

Changes in Health Status Scores in Children Reported to Have a Chronic Condition

Results from the Baseline survey revealed that most children did not report a chronic condition. Children who had a reported chronic condition totaled 831, while children without a reported chronic condition totaled 8,709. The types of chronic conditions that were reported on the questionnaires included asthma, Attention Deficit Hyperactivity Disorder (ADHD) and depression. For the surveys conducted in 2002 and 2003, the proportion of children with a reported chronic medical condition remained consistent with the proportion that was seen at Baseline. Because the population surveyed was stable during the life-span of the project, changes in PedsQL scores are not attributable to shifts in the population.

In examining the differences in health status scores between those children who reported a chronic condition and those who did not, the difference in the Baseline scores was 9.14 points, which the researchers consider to be clinically significant. The subscale with the most significant difference was the school functioning subscale. Table 9 displays the Baseline scores for children with and without a reported chronic condition.

Table 9: Baseline scores for children with and without a reported chronic condition

Scale	Did not report a chronic condition	Reported a chronic condition
Total	82.32	73.18
Physical	84.08	76.99
Psychosocial Health	81.27	71.08
Emotional Functioning	81.20	71.08
Social Functioning	83.05	75.06
School Functioning	78.27	65.58

Table 10 shows the changes in the scores for children with chronic health conditions and scores in the lowest quartile at baseline. When looking at baseline scores for children in the lowest quartile with and without a reported chronic condition and changes from Year 1 to Year 2, we see that the most significant change occurred in physical and school functioning. Children without a reported condition had bigger increases in their scores although all scores for children with chronic conditions showed clinically significant improvement. Children with chronic conditions showed remarkable increases in social and school functioning from Year 1 to Year 2.

Table 10a: Changes in scores for children in the lowest quartile at baseline who had a reported chronic condition

Scale	Baseline	Year 1	Change	Year 2	Change	Net Change
Total	58.79	65.62	6.83	67.93	2.31	9.14
Physical	61.02	68.38	7.36	71.72	3.34	10.70
Psychosocial	57.63	63.75	6.12	65.83	2.08	8.20
Emotional Functioning	59.93	63.18	3.25	64.11	0.93	4.18
Social Functioning	57.63	63.75	6.12	65.83	2.08	8.20
School Functioning	53.17	63.09	9.92	62.53	-0.56	9.36

Differences in scores from Baseline to Year 1 are significant.

Table 10b: Changes in scores for children in the lowest quartile at Baseline who did not have a reported chronic condition

Scale	Baseline	Year 1	Change	Year 2	Change	Net Change
Total	58.25	72.21	13.96	71.38	-0.83	13.13
Physical	53.98	71.37	17.39	71.58	0.21	17.60
Psychosocial	60.70	72.17	11.47	71.31	-0.86	10.61
Emotional Functioning	67.61	73.52	5.91	73.04	-0.48	5.43
Social Functioning	60.70	72.17	11.47	71.31	-0.86	10.61
School Functioning	56.24	69.58	13.34	68.03	-1.55	11.79

Differences in scores from Baseline to Year 1 are significant.

Changes in School Functioning for the Sickest Children

A closer look at the individual items that constitute the school functioning subscales reveals significant improvement in PedsQL™ scores for children with scores in the lowest quartile. Table 11 shows the changes in school functioning. As seen generally in the survey results, the largest change occurred from the Baseline survey to Year 1, but these changes were sustained through Year 2. The items with the largest increase were paying attention at school and keeping up in school activities. Although the scores had an insignificant decrease from Year 1 to Year 2, the net change in scores was positive. For certain items, the increase is so great (paying attention in class, keeping up in school activities) as to show a material effect despite the likelihood that some improvement would have occurred over time regardless of participation in HFP.

Table 11: Changes in PedsQL™ School Functioning Subscale Items for children in the lowest quartile at Baseline.

Subscale Items	Baseline	Year 1	Change	Year 2	Change	Net Change
Paying attention in class	35.00	56.91	21.91	55.13	-1.78	20.13
Forgetting things	60.70	68.50	7.80	66.35	-2.15	5.65
Keeping up in school activities	36.33	59.55	23.22	59.08	-0.47	22.75
Missing school because of not feeling well	72.79	78.18	5.39	77.43	-0.75	4.64
Missing school to go to the doctor or hospital	72.46	77.73	5.27	76.35	-1.38	3.89

Differences in scores from Baseline to Year 1 are significant.

Access to Care

The modified PedsQL™ questionnaire contained three key questions related to access to care. Each parent was asked: (1) Whether their child had a personal physician in the preceding 12 months; (2) Whether their child had no problems getting the care they or their doctor felt necessary (problems getting needed care); and (3) Whether they received the care they needed (foregone health care). The rates for these items increased from Baseline to Year 1 and were sustained from Year 1 to Year 2. The largest increase seen (11.3 percentage points) was for families reporting the presence of a regular physician from Baseline to Year 1. The second largest increase was seen in families reporting no foregone care, the variable researchers believe is the best proxy for access. At Baseline, 84 percent of families reported no foregone care, but by Year 2, 92 percent reported no foregone care. There were some changes in families reporting no problems getting care. At Baseline, 80.2 percent of families reported no problems, and by Year 1 it was up to 83.7 percent.

Table 12: Access over time: The percent of sample reporting the presence of a regular physician, the absence of problems getting care, and foregoing care.

Access	Baseline	Year 1	Year 2
Regular Physician	55.7%	66.4%	66.2%
No Problems Getting Care	80.2%	83.7%	83.8%
No Foregone Health Care	84.0%	91.3%	92.4%

Differences from Baseline to Year 1 are statistically significant. Difference from Year 1 to Year 2 are not significant.

In looking at the changes in having a regular physician among ethnic and language groups, African American children (16.4 percentage points) had the largest increase followed by Latino children (12.7 percentage points). Asian/Pacific Island children showed the least change (4.6 percentage points). Spanish-language respondents showed the largest increase (12.6 percentage points) followed by English-language respondents.

Table 13: The percent of sample reporting the presence of a regular physician by ethnicity and language at Baseline, Year 1, and Year 2

Ethnicity	Baseline	Year 1	Year 2
White	74.3%	82.6%	83.4%
Latino	49.2%	62.3%	61.6%
African American	69.8%	84.2%	86.2%
Asian/Pacific Islander	65.7%	70.0%	69.1%
Language			
English	70.0%	79.9%	78.3%
Spanish	45.2%	58.4%	57.8%
Vietnamese	37.5%	26.5%	30.3%
Korean	48.6%	53.1%	52.2%
Chinese	74.7%	74.7%	81.5%

With respect to the percent of children reporting no problems getting care, the largest increase from Baseline to Year 2 was seen in African American children. Spanish speaking families had the largest change among the five language groups.

Table 14: The percent of sample reporting no problems getting care by ethnicity and language at Baseline, Year 1 and Year 2

Ethnicity	Baseline	Year 1	Year 2
White	87.9%	87.9%	87.7%
Latino	81.1%	84.7%	84.9%
African American	78.8%	84.5%	84.8%
Asian/Pacific Islander	75.0%	77.5%	76.6%
Language			
English	81.5%	83.9%	84.4%
Spanish	80.0%	84.7%	84.8%
Vietnamese	62.5%	62.0%	63.5%
Korean	83.9%	75.0%	80.0%
Chinese	76.8%	79.5%	75.1%

Changes in the percent of children reporting no foregone health care were more dramatic than the changes seen in no problems getting health care. African American and Asian/Pacific Islander children had an increase of over 10 percentage points. Vietnamese language respondents had an increase of 12 percentage points.

Table 15: The percent of sample reporting no foregone care by ethnicity and language at Baseline, Year 1, and Year 2

Ethnicity	Baseline	Year 1	Year 2
White	86.8%	91.5%	93.9%
Latino	84.1%	91.7%	91.9%
African American	83.3%	94.8%	93.9%
Asian/Pacific Islander	83.1%	89.1%	93.3%
Language			
English	84.4%	91.7%	93.3%
Spanish	83.5%	91.2%	91.6%
Vietnamese	80.7%	90.4%	92.6%
Korean	87.0%	92.1%	92.8%
Chinese	86.2%	89.3%	94.4%

Baseline responses received from parents of children with scores in the lowest quartile were most different for problems getting care and foregone care. Children in the lowest quartile had less improvement than children in the top three quartiles, but still significant improvement. Table 16 shows the changes in results for children that continued to be enrolled in the program for 2 years.

Table 16: Changes in presence of a personal physician, problems getting needed care and foregone health care for children with scores in the lowest and top three quartiles at Baseline who remained in the program for 2 years

	Lowest Quartile			Top Three Quartiles		
	Baseline	Year 1	Year 2	Baseline	Year 1	Year 2
Child had a personal physician						
Yes	52.4%	61.6%	60.7%	58.4%	69.0%	68.0%
Child had problems getting needed care						
Yes	29.0%	23.0%	22.0%	18.4%	15.7%	14.4%
Foregone health care						
Yes	25.0%	14.9%	12.1%	15.3%	7.5%	6.2%

Differences in scores from Baseline to Year 1 are significant.

Discussion

The results from this project strongly support the benefits the HFP provides to uninsured children. Access to care increases significantly for all children, including children who are in the most need of medical care. Reported health related quality of life and improvements in school performance for children who are in the poorest health also increase dramatically. Data show variation by race and language by parents reporting the presence of a regular physician and, to a lesser degree, by parents reporting no problems getting care. Virtually no variation occurs by race/language in reports of foregone care--the most important variable associated with access. The largest change in access and in health related quality of life occurred from the Baseline year to Year 1. Gains realized were sustained through Year 2.

There are other factors that may contribute to changes in the health related quality of life which this project could not measure. Factors such as changes in the child's environment and the quality of care provided play a role in whether (or how much) a child's quality of life improves. Aside from these factors, however, analysis conducted by the researchers suggest that access to care, specifically, reductions in foregone care, are important contributors to the improvement in health related quality of life. This is especially true for children who are in the poorest health at the time of initial enrollment in the HFP.

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